Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician BARROLL 2007 CHARLES evember /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Johns Itopkins Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** 218-28-073 1**⊠**M 2□ F **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 21201 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatte event, the Medical Examiner must. Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MTHENTELSE, W. ZIO93 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐Removal from State 5410. (IT), 12. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 17 days **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Septic joint

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Undert in Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Box 68760,2 Due to (or as a consequence of): attending physician for use as the burial Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. | 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed I 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 : After this certificate has Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar RES-000

600 Worth Wolfe STREET

NOVEMBER 1

, MEDILAL DOLTUR

JOHNS HOPKING HOSPITAL

3 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STALY WANG

31. Date filed (Month, Day, Year) NOV 0 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend 8 per F.H g876 2/6/08 er KBH ate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}8 1:35a_M 2 Ở 🗗 7 **Physician** October Jaslyn Caroline Bailey /Medical 4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical center 4b. City, Town, or Location of Death TOWSON Examiner 4c Balt fillbre If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6 Sex 10/27./**@7**Year) **Funeral** 1 M 2 F Days Hours Min. Director None Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examples. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Sheridan Funeral Ave. 21212 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify. 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 0 Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Curtis Bailey Virginia Campbell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 101 N LANCES 6 NO 106 20b. Place of Disposition (Name of gemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 12007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera 22. Name and Address of Facility JENKING + SONS CO. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Extreme prematurity due to cervical incompetence Physician lhr 51 min /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be execute Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmeo? 21Z No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient Certification: To 1 🔲 Yes 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) sompletely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Birenbourn

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

6701 N. Charles

MD

32 Registrar's Signature

Street Baltimore Mil 21204

		For State Registrar	State of Maryl		epartment of I Certificate of		-	giene Reg. No. 4	2007	355	: n :
Physic	an	1. Decedent's Name (First, Middle, Las					2. Date of De Month	Day	Year	3. Time of Di	eath
/Medi	cal	Ermindo John Barso			4h City Town	and agetion of Doot	10-	29 -	ounty of Death	4:40	\mathcal{P}^{M}
Examir	ier	4a. Facility Name (If not institution, give Fran Klin Square	11050/fal (1 / 100	Boseda	or Location of Deat	n	Ro	1ti more		
Funeral		Social Security Number 6. Security Number	7. Age (In	yrs. last birtho	lay) If Under 1 Year	If Under 24 Hrs.		in .	9. Birthp	lace (State or r	-oreign
Director		217 30 33.	Дм 2□ F 73	Yr	s. Months Days	Hours Min.	Sept.		4 Cour	MD	
and *	1	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town o	r Location				1	0d. Inside City	Limits
Maryla f sho	ō	MD Balt:	imore	Fu11	erton					1 □Yes 2	
r 28a-	Director	10e. Street and Number			10f. Zip Code				en of What Cour	itry?	
th with	a D	10 Wildwood Rd			21206			USA			
r dea tems	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	 Was Decedent of If Yes, specify Cub 	Hispanic Origin? (S ban, Mexican, Puer	Specity Yes or No to Rican, etc.)	- 14	 Race - Americ Black, White, 		
36 rs afte	by F	1 ☐ Never Married 2√√√Married 3 ☐ Widowed 4 ☐ Divorced	1 □X es 2 □ No If Yes, Give Year or Dates:		1 □ Yes 21∏ No	Specify:		s	Specify: Whi	te	
Maryland 21215-0036 to 2 should be filed within 72 hours after death with the Maryland tht and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	ted	15. Decedent's Ed	ucation	16a. D	ecedent's Usual Occu	pation		16b. Kind	d of Business/In	dustry	
215 thin 7 e. an "n Medi	Completed	(Specify only highest gra-	College (1-4or 5+)	- Ch	Give kind of work done fe. DO NOT use retire eet Metal	e auring most ot wo ed) Moobanic	rking	Uni	on		
d 21 filed wi Hygien ther th	ပ္ပ	12		511	eet Metai						
and lbe fil ntal H ed otl	Be	17. Father's Name (First, Middle, Last)				Mary	me <i>(First, Middle,</i> Alvath		urname)		
aryla should I and Men's marker umatic	욘	John Vincent Bars 19a. Informant's Name/Relationship (7)		19b. N	Mailing Address (Stree				Town, State, Zin	Code)	
IOCE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylar tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Constance Barsott		1	Wildwood R		more, MD	-			
of Her of Her fitem		20a. Method of Disposition	Domesti from State	Ob. Place of D	isposition (Name of crematory or other pla	ace)	Date	20c. Loca	ation - City or To	own, State	
Pages Pages ment of ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval from State		d Mem. Par	k 11/	2/07		imore,		
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item; any injury or other once.		21. Signature of Funeral Service Locen	No.		22. Name and Addr		iller-Di Baltimo				Inc
		23a. Part1. Enter the diseas , seomi	olications that caused the	doath Dono	6415 Bela				ID 21200	Approximate	
E-to-		shock, or heart failur. Ist only	one cause on each line.					11651,		Interval Betwee	en eath
Physician /Medical		disease or condition resulting in death	a. Hypoxic	sequence of)	piratory	tall ure	,				
Examiner			COPI)							
D ==	je.	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor	nequenns of)							
ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Smoki								
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68760, ificate be executed physician and ts the burial-transit	edical		.d		,						
	M/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pr	egnancy	2DEstania smanan	011		23	3d. Date of deliv	ery	
deatl	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су			Month	Day Ye	ar
Hecords, P.O. Box The law requires that the death cert tte has been signed by the attendin page 2 should be detached for use.	Physician/M	9 ☐ Unknown Part II. Other significant conditions c		t reculting in th	a conducting access of	iven in Dert I	220 Did i	obacca un	e contribute to t	ha causa of day	ath?
ds, lires the signer	by		Nal Failur	-	ne underlying cause gi	iveii ii Faiti.	1230. 110			bably 4 ∏Un	
v requ	etec	11-Tal	Nat Therese.			·	24a. Was			opsy findings av	vailable
DIVISION OF VITAI RECORDS, or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be do	Completed	11 . 2021: 11	· · · · ·	6000/	Vagaula	2 1/2 - 160	auto	psy ormed?	prior to co death?	impletion of cau	ise of
	Be Co	Hyperlipiden 25. W se referred t medical	na rerip	neral	Vascular	26. Place of De	ath (Check only o	2 (No one)	1 ☐ Yes	2 NO	
nysic)	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ☐ ER/Outp	atient 3 DOA Ot	ther: 4 Nursing I	Home 5 ☐ Resi	dence 6	□Other (Speci	fy)	
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ttendi death.	cati	2 Accident investigation 3 Suicide 6 Could not be		At home farm	M 1 [n, street, factory, office]Yes 2 □ No	29f Logation /	Stroot and	Number or Run	al Pauta Numb	or.
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Hospital 14 hours Funeral tely filled	al C		ysician: To the best of my								
Division or Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica	ledical	(Check only 2 ☐ Medical Exam one)	niner: On the basis of exa and manner stated.	mination and/	or investigation, in my	opinion, death occ	curred at the time	, date and _l	place, and due f	to the cause(s)	
To the within 2 To the comple	Σ	29b. Signature and title of certifier				15e number 33445	-		signed (Month,		
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1210		30. Name and address of person who	completed cause of death	(Item 23a) (T	ype, Print)	Drive B	a / Limit	0 1/1	7172	1	
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Sycare	DIIVE D	W I TIMO	-JMa	46	(
Regist		NOV 0 6	2007	10	1.0						
DHMH 17 Rev 1/2	2001		1 de la constitución de la const	15	MARKET						

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Bassotti Brmindo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** James Leroy Carter November 1 2007 24AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Itimore Huspitel N/AIf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 218-22-9693 Months 12 M 2□ F Hours 1928 Maryland 11, Director Jan. Usual Residence of Decedent 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Baltimore N/A Maryland Director 1 XYes 2 No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 2 2849 W. Coldspring Lane 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. k 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗗 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any injury or other traumatic event than "ne once. Container Corporation Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator 12th grade 17. Father's Name (First, Middle, Last)
William Carter 18. Mother's Name (First, Middle, Maiden Surname) Alice Gaither 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Flural Pouts Number Sity & Principle 21215 2849 W. Coldspring Lane Bait & Principle 21 21215 Wife Mary Betty Carter/ 20b. Place of Disposition (Name of cemeter), crematory or other place)
Mt. Zion Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/6/07 Mt. Lansdowne, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immer ate Cause (Final sease or condition resulting in death) **Physician** ardiac 15 minules /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): as the burial-transit and % Due to (or as a consequence of): Of ter James Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hyperlension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perforn Kupin bon 1∐ Yes 25. Was case referred to medidal examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manny of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MIS DEA BL 99 16795 November 1, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bulhmore, Mayland Meghan Checkley 900 South Caton Avenue

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 6 2007

Granke !

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 35505 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year 4.37 PM CORNIAS NOVEMBER /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD GENERAL HOWARD COUNTY HOSPITAL COLUMBIA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace Country)
April 9, 1935 Greece Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months Days 72 215-30-8185 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hygiene. Important; If Item 27 is marked other than "natural"..." 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Delaware Sussex 1 ☐Yes 2 🕅 No Director Selbyville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 37038 Teal Court 19975 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Restaurant Owner <u>Restaurant</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Constantine Dimitrios Cornias Anthoula Pikounis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kalliopi Cornias - Wife 37038 Teal Court; Selbyville, DE 19975 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11-5-2007 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue: Catonsville, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** PROBABLE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Examiner PNEUMONIA BACTERIAL Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed <u>ال</u>ة Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 1 ☐ Yes 5 Other (specify) 2□No the 9 I Inknown 9 ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? 9 END-STAGE RENAL DISEASE 2 No 3 Probably 4 Unknown 1 Tyes Completed CONGESTIVE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? after death. Certification: 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) 063242 NOVEMBER OI 2007 SVITE 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 LITTLE PATUXENT PARKWAY COLUMBIA NIRAV G. SHAH 21044 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 6 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Day 2 Year **Physician** DOUGHERTY CARPER 2:00 A M November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Hours Months Days 1 M 200 **Director** 217-70-6716 42 July 19, 1965 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f shor the Medical Examiner must be notified at Director 1 Yes 2 No MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15715 Bond Mill Road permit. Pages 1 and 2 should be flied within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a amy injury or other traumatic event, the Medical Examiner must once. 20707 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th Stock Investor Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Herbert Dougherty 2 Dolores Giknis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Lee Carper/Husband 15715 Bond Mill Road, Laurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State

Physician /Medical Examiner 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed signed to certificate ha after death

Director: within 24 hours aft

To the Funeral D

completely filled in

4 Donation 5 Dotner (Specia	west Ai		/2007 Ode		
21. Signature of Funeral Service Licer	nsee	22. Name and Address of Facility DC	naldson Fu	neral Hon	ne, P.A.
Janeces	M01103	313 Talbott Avenu	e, Laurel,	MD 2070	7
	plications that caused the death. Do no one cause on each line.	t enter the mode of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between Onset and Death
Immediate a (Final disease or condition resulting in death)	a. Advance Broo	chogenic Carcinoma			Onset and Death
resulting in death)	Due to (or as a consequence of):			
Sequentially list conditions	b. Bilateral Pr				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or se a consequence of	x			
that initiated events	c. Left Lower I	Lube Atalectasis			
resulting in death) Last	Due to (or as a consequence of):			
	Left Pleural	L Effusion			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	livery Day Year
Part II. Other significant conditions	contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Chronic Obstruct	ive Lung Disease		1√∑ Yes	2□No 3□Pr	robably 4 ∏Unknown
	-		A.		
Bilateral Renal		W	24a. Was an autopsy performed	24b. Were au prior to death?	utopsy findings available completion of cause of
	lure		1□ Yes 2🔀		2 No
25. Was case referred to medical examiner?	Haspital		ath (Check only one)		
1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ☐ ER/Outp		Home 5 ☐ Residence		cify)
27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	n	me of ury Mork? M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, St.	and Number or Ru ate)	ural Route Number,
29a. Certifier (Check only one) 1	nysician: To the best of my knowledge, miner: On the basis of examination and/ and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occ	e, and due to the cause curred at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
29b. Signature and title of certifier	you MD	29c. License number D 2 2-6		Date signed (Monte	
30 Name and address of person who SHRIMIVAS R. L	completed cause of death (Item 23a) (Ty IDAPI. 7245B	ype, Print) HAWOUER PARKW	AYGREE	NBELT	MD 20770

DHMH 17 Rev 1/2001

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State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 6 2007

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N2 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** oumont lenora int 2007 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner reen a 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace Country) 1 □ M 2 1 1 F -34-7031 94 Davs Hours Min MARYland Director 1913 Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** everna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21146 USA ergreen Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ,o Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 1 ☐ Yes 2 No Specify þ Specify: white 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home 8 N/A Housewife Department of Health and Mental Hygis Important: If Item 27 is marked other I any Injury or other traumatic event, <u>tt</u> <u>once,</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellenora Wilson William Schelde ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Evergreen Trail, Severna Park, MD 21146 Donald Coumont- SON 20a. Methed of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Nov, 3, 2007 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee EVANS FUNERAL CHAPEL & CREMATION SERVICES 8800 Harford RD, Parkville, Maryland 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARDIOVASCULAR 10 y eurs /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 HO 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has birector, page 2 s autopsy performed 1∐ Yes 20 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Beemence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) וו 24 hou.. the Funeral Direc. יאיר filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor **To the Fune** completely fi (Check only 29b. Signature and title of certifier 038687

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-2, My

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

			For State Registrar		State o	of Mary	land / De <i>C</i>	partme <i>ertifica</i>	nt of H te of D	ealth a Death	nd Me	ental Hy	giene	200	7	3550	8 (
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>	Examin	- 10-2	4a. Facility Name (If not 1736 Earh			ımber)		4b. City		Location of SEX	f Death		4c.	County of Dalti		·e	
	Funeral Director		5. Social Security Number 216-28-9125	1	ех □м 2⁄Д г	7. Age (I	n yrs. last birthdi 75 Yrs	Months	Days	If Under 2 Hours	Min.	B. Date of Bir (Month, Da Feb.	th 26, Year)	1932	Birthpl Count Mar	ace (State or For ryland	eign
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<u>o</u>	ath. rr: Afte	atior	Natural 5 2 ☐ Accident	☐ Pending investigation		nth, Day Y	ea <i>r)</i> Inju	ry M	Worl	k? Yes 2 🔲 l	No						
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely illied in by the funeral director,	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not b determined	Zoe. Flat	e of injury ding, etc. (- At home, farm Specify)	street, fact	ory, office		21	8f. Location City or To	(Street a	nd Number e)	or Rura	l Route Number,	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Elmer Matthew Doxzon, Jr. November 1, 9:00 A. M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Health Care Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1₩ 2□F 212-20-0487 Director June 13,1926 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 □ Yes 💥 No Director Maryland Anne Arundel Severna Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 77 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be 1 21146 USA 24 Truck House Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or Ite 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Textile 12 Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beulah Marie Miller Elmer Matthew Doxzon, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6336 Amherst Avenue Columbia, Maryland 21046 Jeffrey Doxzon 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
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Important: If Itel
any injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/6/2007 Metro Crematory Catonsville, MD 4 □ Donation 75 □ Other (Specify) 22. Name and Address of Facility 21. Signature of F ineral Service License Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hea dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Leumonia disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examiner rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown signed by the aid be detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 WKnown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy perform 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No ပ this 27. Manne of Death the funeral 28a. Date of Injury (Month, Day Year) 28b Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death. 1 🗌 Yes 2 🗌 No 2 Accident 3 ☐ Suicide 6 □Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of cortifier 29d. Date signed (Month, Day, Year) 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) Registrar's Signature

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygier 0.735511 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200⁵7 Margaret Karen Day November 6:00 РΜ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care-Bethesda Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. 009-14-9529 80 Director Sept.12, 1927 Vermont Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or iteme 23e or 28e-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10007 Holmhurst Road 20817 United States Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours efter deet Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "neturel" ~ "-- eny injury or other treumatic svent." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Batease Murdena Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lugene S. Day/Husband 10007 Holmhurst Road, Bethesda, Maryland 20817 ov. 5, 2007 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Parklawn Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. ^¹ 4 □ Donation 5 □ Other (Specify) Rockville, Maryland Park Robert A. Pumphrey Funeral Home/Bethes la-Chevy 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature of Funeral Service Licensee M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Atherosclerotic Heart Disease >month /Medical Due to (or as a consequence of): Examiner Myocardial Infarction >weeks Sequentially list conditions, it any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or es a consecuence of Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed <u>Cerebro Vascular Accident</u> >weeks Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 💢 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Munknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 🗌 No 1 Yes 2 🔀 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 To the Hospitel o within 24 hours aft To the Funerel Di completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) luan ress of person who complet 30. Name and a cause of death (Item 23a) (Type, Print) Raman R. Tuli, M.D. 10810 Darnestown Road #202, Gaithersburg, Maryland 20878 31. Date filed (Manage Pay, Year) 32, Registrar's Signature State 2007 Registrar

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	/Medic Examin		4a. Facility Name (If not institution, giv	1	•		4b. City, T	own, or	Location o	f Death		4c. C	ounty of Deatl		
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	12 should heard 7 is more treum		19a. Informant's Name/Relationship (William E. Dovel)	**	on	1					i Route Numbe New Fre	-			
Baltimore,	8 = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		_ Ge	lace of Dispo emetery, crer Lawn	natory or oth	her place		Nove			ation - City or		
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Patient Known as Deborah Denson
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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		T = State Registrar		Cert	ificate of	Death		Reg. No.	2007	7 35513
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ž	29b. Signature and title of certifler			29c. Licens	e number		29d. Date	e signed (Mon	th, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 23e per doc 9874 12-13-07 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician vans Corae 200 WINDMER /Medical ility Name (ot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL Social Security Number 6. Sex 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 219-16-5316 1**X**M 2□F Months Days Hours Min Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD timore 1 Xes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21229 ossu ISH 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 XYes 2 ☐ IFYes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Blac 1 ☐ Yes 2 No Completed by Specify 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working ife. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Parrows 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ames vans ဂ္ ames 19a. Informant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number or Bural Route Number, Gity or Town, State, Zip Code) Kossuth 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) of Funeral Se 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC CULON CANCRIL Physician UNKNUE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tra Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): the IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No GERrobably 4 Munknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 ritiging Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hour To the Fune completely fi (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DUUS1865 2007 NOWEMBER Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGNOS HUSPIME BUTENMORE Mimuns CURTIS 32, Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 6 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Murray Eiler 2007 35515 Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle Last) Physician/ Month Day November 2, 2007 0129 hrs Medical Examiner Murray Eiler 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Mercy Hospital 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or If Linder 1 Year If Linder 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Maryland Director 217-28-5051 1 X M 2 F 80 May 21 1927 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No or items 23a or 28a-f show must be notified at once, N/A Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 6 East Read Street 21202 USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes Specify: White 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Widowed or other traumatic event, the Medical Examiner 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 hours 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government Social Security of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Magdalene Eckstine Be Murray E. Eiler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tippett Lane Montgomery Village, MD 2088
position (Name of cemetery, Date | 20c. Location - City or Town, State Lisa E. Anderson, Niece 9531 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 11/05/07 Baltimore, Maryland Metro Crematory Inc. mportant: Donation 5 Other Specify: 21. Signature of Funeral Service Licensee

Thomas Gregor

22. Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Applications that caused the death. Approximate Interval Physician Between Onset and failure. List only one cause on each line 'Medical Death Complications of multiple injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED #23a.27 ending physician use as the burial 28a-f. nerME g874 12/3/07 TT To the Hospital or Attending Physician: The law requires that the death certificate be-Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Year Live birth 3 Ectopic pregnancy **Fetal death** past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? death? ✓ Yes 2 No 1 V Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other 4 Nursing Home 5 Residence 6 ER/Outpatient 3 DOA this 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Natural Yes 2X No within 24 hours after death To the Funeral Director: Pending FNd 11.1.2007 FNd 4:16 pm the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. X Could not be 3 Town, State) Read St. Apt 505 Baltimore, MD 6 E. determined (Specify) House Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. November 2, 2007 OK DENG. 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 6

32. Registrar's Signature

Box 68760, P.O. Records, Division or Vital

death with the Maryland

filed within 72 hours after

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Maryland 21215-0036

Baltimore,

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requires that the death certificate be executed and physician a s the burial-1 attending p the þ signed t been page 2 s certificate I director, this funeral After filled in by

To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After

29a. Certifier 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tit November 2, 2007 D53691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6320 Democracy Blvd., Bethesda, Maryland 20817 Ajay Reddy, M.D. 32. Registrar's Signature 31. Date filed (Month, Day Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** SUZANNE LEE ESPY 3:00 AM 2007 νου /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPICE CARE MONIUM MARIS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1□M 2 F Days APR Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director mo BALTIMORE TOWSON 10e. Street and Number 10g. Citizen of What Country? 21286 STONE BARN ROAD USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: WHITE þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SAMARITAN Elementary/Secondary (0-12) College (1-4or 5+) GISTERED NURSE Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY ESP KONALD ELIZABETH WOOMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115-2 19a. Informant's Name/Relationship (Type. Print) APT 205 STMARKWAY RONALD H. ESP 517 WESTMINSTER, MO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 12 Burial 2 □ Cremation 3 □ Removal from State KEVIEW mem PARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. P 11. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician OVARIAN CANCER** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 2X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE ² 1 ☐ Yes 2 ▼ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32 Registrar's Signature NOV 0 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year November 4, 2007 **Physician** 2:20 A. M Katherine P. Fahey /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manor Care Falls Road Baltimore N/A8. Date of Birth (Month, Day, Year) 9. Birthplace (State or For Country)

Pennsylvania If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 ₩ F Dec. 89 173-03=3101 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County XXYes 2 □ No Director Maryland N/A Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4669 Falls Road 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2CXNo Specify þ 3 Vidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Franklin Balmar Elementary/Secondary (0-12) College (1-4or 5+) Machinist Industry 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Funk Mary Whitlock ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Fahey 709 County Road C.W. Roseville, MN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial 11/7/07 Timonium, MD 4 Donation 5 □ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road, Baltimore, Maryland 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. En of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Deehm Examiner Mershors Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 19ther pu 20 The law requires that the death certificate be executed and as the burial-trai Due to (or as a consequence of): attending physician Physician/Medical nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 2 No 3 Probably 4 donknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has director, page 2: autopsy performed' certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To the Hospina. Sufficiently within 24 hours after death.

To the Funeral Director: After this committeely filled in by the funeral director. 3□ DOA 1 Inpatient 2 ER/Outpatient Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

821 N. ENTAW

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ital or led in Die	Certification:	4 Homicide dete	ermined (Specify)	11040								ville, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici rounlerely filled in by the funeral director, page 2 should be detached for use as the burit	a C	29a. Certifier (Check only 1 Certifying F	hysician: To the be	st of my knowle	dge, death oc	curred at the	time, date and pla	ice, and di	ue to the cause	(s) and manner	as stated. ue to the cau	se(s)
Fo the within Fo the	Medical	one) 2 Medical Exa	aminer: On the basis and manner:	of examination stated.	and/or investi		: License number		- Carro	29d. Date sign	ed (Month, D	ay, Year)
	Σ	29b. Signature and title of certific	er			290	O.C.M.E.			November		
		mesz	a who completed se-	se of death (lin	am 23a)							
(10) Ø		30. Name and address of perso Ana Rubio MD. As	n who completed cau sistant Medical		111 Peni	n Street, E	Baltimore, MD	21201				
(')	State	31. Date filed (Month, Day, Year		Registrar's Signa	ature for	ask)	-					
Regi		MOW O Z	2007	resident of	1	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year 53 PM REDERICK 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GENES15 CROMNEL Baltimore Parkville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 186-24-2158 February 26,1925 | Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2√ No Dundalk Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 8019 Park Haven Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 TYYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Assembly Line Worker National Can <u>12 years</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella Frinnefrock Joseph J. Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8019 Park Haven Road, Dundalk, Maryland 21222 Dorothy Mae Wagner Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) November 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland Oak Lawn Cemetery 3,2007 21. Signature of Funeral Service Licensee Conner of Address of Facility Home Of Dundalk, P.A. alk, Md. 21222

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

11/1/02

21200

Physician /Medical **Examiner**

1 - State Registral

10a. State

Directo

Funeral

<u>^</u>

Completed

Be

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be notified any injury or other traumatic event, the Medical Examiner must be notified.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Completed by To Be Medical Certification: within 24 hours after death

To the Funeral Director:
completely filled in by the

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

(Inthony	Lonnelle	7110	Sollers Point	Road, Dune	dalk,Md.	21222
23a. Part1. Enter the disease, or compl shock, or heart failure. Ust only or	ications that caused the deat ne cause on each line.	Do not enter the mo	de of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	Danenhi					heris
resulting in death)	Due to (or as a conseq	uence of):				Jen 1
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):				
Cause (Disease of Injury						
that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
	220 10 (01 20 20 20 20 20 20 20 20 20 20 20 20 20					
	d					
in the past 12 months?	23c. If yes, outcome pf pregni 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3□Ectopic i		-	23d. Date of de Month	livery Day Year
9 ☐ Unknown						
Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
Prenia				1 ☐ Yes	2 N o 3 ₽	robabły 4 □Unkno
				24a. Was an autopsy	prior to	utopsy findings availa completion of cause
				performed? 1☐ Yes 2 ☐	death? do 1 ☐ Yes	2 □ No
25. Was case referred to medical			26. Place of De	ath (Check only one)		
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 D	OA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Spe	ecify)
27. Manner of Death 1 ☐ Hatūral 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, factory)	ry, office	28f. Location (Street City or Town, Sta	and Number or R ate)	ural Route Number,
	sician: To the best of my kno iner: On the basis of examina					

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Kloese

06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N Charles

32 Registrar's Signature

Suti

29c. License number

D 31296

7. wsn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 35521 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 10:15 A.M 2 10 31 ility Name (If not/institution, give street and pumber) 4c. County of Death 9 Birthplace (State or Foreign Country) Days 1 M M 2 □ F Usual Residence 10c. City, Town or Location 1 ☐Yes 2 ☐ No 13 aruland 10g. Citizen of What Country? t and Number 10f. Zip Code Was Decedent Evel Armed Forces?

1 Yes 2 No No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Location 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of fluneral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESISTANT SEPTIC Due to (or as a consequence of): 1XLY SUS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

Completed by

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Funeral

Director

Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or Items 23a or 28a-f show important; if Item 27 is marked other than "natural", or Items 29a or 28a-f show important; or other traumatic event, the Medital Examiner must be notified at once.

death with the Maryland

and 2 should be filed within 72 hours after

Pages 1

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed the burial-trai physician ed by the attending detached for use as signed by to peen certificate has funeral director, After this

Examine Physician/Medical þ Completed Be Certification: To or Attending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Ai completely filled in by the fu Medical

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions of		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
(3) ADVANCE	D AIDS	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of De th Natural 5 Pending Accident investigation		28d. Describe how injury occurred
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	nysician: To the best of my knowledge, death occurred at the time, date and place miner: On the basis of examination and/or investigation, in my opinion, death occu and manner stated.	
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month. Dav. Year)

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BALTIMONE

2007

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State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 234) (Ty.

2007

Year)

NOV 0 6

Registrar's Signature

			_ For	State of Ma	aryland /	Depar	tment of F	lealth an	id Ment	al Hygi	iene	og.bic.		
			State Registrar			Cert	ificate of	Death			g. N2	007	355	
4	Physicia	an	Decedent's Name (First, Middle, La		T1		-1		N	ate of Deatl Ionth	Day	Year	3. Time of	
	/Medic	al .	4a. Facility Name (If not institution, give		Jackson		aham 4b. City, Town, o	r Location of D	NO.	V 4	4,	2007 county of Dea	02:58	A W
	Examin	er	St. Agnes Hosp				-	imore	Jean		40.0	•	/A	
	Funeral		5. Social Security Number 6.	Sex 7. Ag	ge (In yrs. last I		If Under 1 Year	If Under 24 I	Hrs. 8. D	ate of Birth	Vone)		thplace (State o	or Foreign
	Director		216-16-0767	1 X M 2□F	85	Yrs.	Months Days	Hours N	Min. J	ate of Birth Month, Day, JL 15,	192		aryland	
	pur »		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loca	ation						10d. Inside C	tv I imits
	Aaryla f sho ed at	ō		imore				nsville					1 □Yes	
	the rotifi	rect	10e. Street and Number	пиоте		<u>.</u>	10f. Zip Code	1211116	-	10	0g. Citize	en of What C	ountry?	
	th with	Funeral Director	717 Maiden Cho	ice Lane,	STC 225	5	2	21228				USA		
	ems :	Iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.		as Decedent of H Yes, specify Cub		n? (Specify)	Yes or No-	14	1. Race - Ame Black, Whi		
36	or it	Y. F.	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □	No		∃Yes 2【 X No	Specify:		,	8	Specify:		
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15	nin 72 n "na Medic	plet	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or t		(Give ki	nd of work done O NOT use retire	during most of	f working		, , , , , , , , , , , , , , , , , , , ,		, , , , , , , , , , , , , , , , , , , ,	
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nd	pe file	Be (17. Father's Name (First, Middle, Las	⁹				18. Mother's	Name (Firs	st, Middle, N	/laiden S	Gurname)		
yla	should be filed within 72 hours after death with the Maryland rind Mental Hygiene. Ind Mental Hygiene. Inarked other than "natural" or items 23a or 28a-f show in marked other than "natural" or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	٦ ا			aham				ura			entz		
40	0.00.00		19a. Informant's Name/Relationship				Address (Street							
ė,	Health Health tem 27 i		Gary A. Graham, 20a. Method of Disposition	son	20b. Place	of Disposi	Green Ac	1	.Cl Date			Mary1 ation - City o		286
Baltimore,	Pages nent of I ant: If ite		1 ☐ Burial 2 XCremation 3 [4 ☐ Donation 5 ☐ Other (Spec	Removal from State	: I		atory or other pla matory,	1	1/06/			1timor		
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Ŗ			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that causer one cause on each li	d the death. D	o not enter	the mode of dyi	ng, such as car	ardiac or res	piratory arre	est,		Approximat Interval Bet	ween
Œ.	Physician		Immediate Cause (Final disease or condition	, Septi	c Sho	ck							Onset and	Death Ours
	/Medical Examiner		resulting in death)		a consequenc									
	Lxammer	<u>_</u>	Sequentially list conditions, if any, leading to immediate	U. —	e Per		itis						3 Day	ys
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Ć	execun and ial-tra	Exal	that initiated events resulting in death) Last	C	a consequence								/ Da	y 5
,160,	icate be executed physician and s the burial-transit	cal		d										
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Вох	ath ce ttendii or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐Live birth		ath 3□E	Ectopic pregnanc	су			23	3d. Date of de		Year
0	ne deg the at hed fo	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of death	5 🗆	Other (specify) _					WOITH	Бау	I Cal
<u> </u>	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Phy	Part II. Other significant conditions	contributing to death t	but not resulting	in the und	derlying cause gi	ven in Part I.		23e. Did tob	pacco us	e contribute	to the cause of	death?
ds,	uires signe	d by		· ·			, , ,			1 🗖 Y€	es 2□]No 3 [X]F	robably 4 🗆	Unknown
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or Vital Records,	Attending Physician: The in death. ector: After this certificate h. by the funeral director, page	To E	examiner? 1 ☐ Yes 2 X No	Hospital: 1 XInpati	ient 2 ER/	Outpatient	3□ DOA Oti	her: 4 🗆 Nursii	ing Home	5 Reside	ence 6	☐Other (Sp	ecify)	
ם ס	ding Pl n. After tl funera	ou:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28t ay Year)	o. Time of Injury		rk?		Describe ho	ow injury	occurred		
sio	ttendi leath. tor: / the fu	cati	2 Accident investigation 3 Suicide 6 Could not l	26		f]Yes 2∐No						
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 ☐ Homicide determined	20e. Place of in	itc. (Specify)	rarm, stre	ет, тастогу, опісе			City or Town		Number or F	Rural Route Nur	nber,
	spital		29a. Certifier 1 X Certifying P	hysician: To the best	t of my knowled	lge, death	occurred at the t	ime, date and p	place, and o	due to the c	ause(s) a	and manner a	is stated.	
	To the Hospitai or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only 2 ☐ Medical Exa one)	miner: On the basis of and manner a	of examination	and/or inve	estigation, in my	opinion, death	occurred at	t the time, d	late and	place, and du	ie to the cause(s)
	To the Comp	Ě	29b. Signature and title of certifier				29c. Licen	se number		2	9d. Date	signed (Mor	nth, Day, Year)	
)			Meec	2	4) (J ,	P207	778			Nov	ember	5, 20	007
	11		30. Name and address of person who						Т.	. 7			•	
	WX1		Anton Gueorgu 31. Date filed (Month, Day, Year)		• 900 trar's Signature			Avenue	e Ba	altim	ore	, MD	21229)
	Sta Registr		NOV 0 6	2007	September 1	A	railes							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** November 5,2007 12:55 AM /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner 1216 Jast birthday **Funeral** Months Days Hours Year) MOHNA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Tes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Black, White, etc. rmed Forces?

☐ res 2 ☐ No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Specify. 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working inc. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's N 9 2 Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Numbe 9171/5T 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation / 15 ☐ Other (Specify) uneral Service ENT, MI 21. Signature HUNDRA 23a. Patri. E e Indisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat + C+ use (Final disease of condition resulting in death) Kena Physician weeks. /Medical Due to (or as a consequence of): **Examiner** weeks evere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ovance meana attending physician and for use as the burial-tran Directo (or as a consequence of) P.O. Box 68760, Physician/Medical VIOR 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the 9□Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 2 No 1∐ Yes Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Tes 3□ DOA Certification: To 2 ER/Outpatient After this 27. Manney of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) thospital Hosk 10100 n umorial Nown

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0

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Registrar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM/4b c perPHYS //9 20b perPHYS OF Maryland / Department of Health and Mental Hygiene OF Reg. No. 35524 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ucille Stukes Hall Month 40 M 10 Ш 04 OI. /Medical Am Examiner 4b. City, Town, or Location of Death 4c. County of Death ionvalescent + N. ewish <u>Pikesville</u> Baltimore Birthplace (State or Foreign Country) last birthday) 1 Year Days 8. Date of Birth (Month, Day, **Funeral** Hours 1 M 2 X F Months Min. 213-26-4279 Yrs Director SC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? usA 21217 1640 Gwynn Falls Farkway 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ring most of working (Give kind of work done du life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) cure Eather's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number f Health a 40 Gwynn MD21217 Balto. 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 'Department of Himportant: If Ite any Injury or ot 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) emetery, crematory or other place) 3 ☐Removal from State Baltimore, 21. Signature of Funeral Service Licensee Addless of acility Greene Rd. Randallstown, MD 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, suc shock, or heart lailure. List only one cause on each line. Immediate Cause (Final et whach on **Physician** 15min disease or condition resulting in death) /Medical (or as a consequence of): Examiner al milla moull. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy After this certificate has been signed by the after funeral director, page 2 should be detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 nown Be Completed 24a. Was an autopsy performed?
1☐ Yes 2☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1/ Natural 5 Pending investigation 24 hours after death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 144817 NUV.06-2007 0, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Selvedere ane Balkmore 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () 35525 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Dorothy M. Hoopes 7:44 P.M 1, 2007 November /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Wilson Health Care Center Gaithersburg If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🔀 F July 15, 1914 Washington, DC 93 578-48-0234 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Gaithersburg |Maryland|Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20877 415 Russell Avenue #810 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Duckett Wilmot W. Trew

20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill

Cemetery Mausoleum

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906

3200 N. Leisure World Blvd. #316, Silver Spring, MD

Robert A. Pumphrey Funeral Home/Rockville, Inc.

Date

Nov. 9, 2007

20c. Location - City or Town, State

November 2, 2007

Suitland, Maryland

Physician /Medical

Funeral

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Inter If Item 27 is marked other than "natural", or Items 23a or 28a-f show

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, I

19a. Informant's Name/Relationship (Type. Print)

20a. Method of Disposition

21. Signature of Funeral Service Licen

James A. Summers, Jr./Son

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 □ Donation 5 ☑ Other (Specify)entombment

Baltimore, Maryland 21215-0036

Examiner

24 hours after death • Funeral Director: filled in by the

law requires that the death certificate be executed

Hospital or

Division or Vital Records, P.O. Box 68760,

23a. Part1. Enter the disease, or o shock, or leart failure. List of	omplications that caused the death. Do not enter the mode of dying, such as cardiac or really one cause on each line.		Approximate Interval Between Onset and Death
Immediate Cause Trinal disease or condition	Cerebrovascular accident		10 days
resulting in death)	Due to (or as a consequence of):		
	Carotid atherosclerosis		years
Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):		
cause. Enter Underlying Cause (Disease or injury that initiated events			
resulting in death) Last	c. Due to (or as a consequence of):		
	d	1	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12t No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of Month	,
Part II. Other significant conditio	ns contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contrib 1 ☐ Yes 2 ☑ No 3	ute to the cause of death? ☐ Probably 4 ☐Unknown
diabetes melli	115	24a. Was an 24b. We	ere autopsy findings available or to completion of cause of
hypertension		performed? de	or to completion of cause of ath? ∃Yes 2□No
25. Was case referred to medical examiner?	26. Place of Death (C		
1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home	5 ☐ Residence 6 ☐ Other	(Specify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d.	Describe how injury occurred	d
3 Suicide 6 Could n 4 Homicide determi		Location (Street and Number City or Town, State)	or Rural Route Number,
	p Physician: To the best of my knowledge, death occurred at the time, date and place, and xaminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		
29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and

31. Date filed (Month)

John A. Melnick, M.D.,

NOV 0 6

dress of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

D19294

911 Russell Ave., Gaithersburg, Maryland 20897

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 Day 9 Physician WILBER HINES OCTOBE 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BACTIMOTE IN ACHINIGTON MEDIZAL CE AMNE CITEN BURNIE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Min. 1 X M 2 □ F 08/01/1930 MD Director 212-26-0217 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7975 Crain Hwy, S Unit 304 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Underwriting Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leona Irene Barnes ္ရ Wilbert John Hines, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21061 Mrs. Vivian E. Hines / wife 7975 Crain Hwy, S Unit 304 Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 11/05/2007 Stevensville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave SW, Glen Burnie, MD MO1357 Singleton Funeral & Cremation Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYC CARDIAL resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as the attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 4 Unknown 1 Yes 2 No 3 Probably Completed .24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perform certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manny r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ature and title of certifier 29c. License number 2d. Date signed (Month. Day, Year)

0 State

State Registrar o Manne and address of person

31. Date filed (Month, Day,

o completed rause of death (Item 23a) (Type, Print)

32 Registrar's Signature

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2007 35527 07-08508 State of Maryland / Department of Health and Mental Hygiene 1-For State Amend #20bxc Fer FH 68/3 11/19 Autificate of Death Leonard Holmes Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day November 1, 2007 Physician/ 2304 hrs 0 Medical Examiner EONARD 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltmore 816 Newington Ave. If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Country) Director 7067 95 1X M 2 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 'n 1 Yes 2 No s 23a or 28a-f show e notified at once. hours after death with the Maryland 10q. Citizen of What Country Director 10f. Zip Code 10e. Street and Number 5 816 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filted within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be: Armed Forces? 2 X Married Never Married 2 No Yes Yes 2 No specify: If Yes, Give Year Divorced 3 Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ni ECE BA NEW INSton AVE 110 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 X Cremation 3 Removal from State 11/12/2007 Greenmount Crematory Other Specify Donation 5 Phillip A WEATHERFORD Signature of Funeral Service Licer Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Retween Onset and Physician failure. List only one cause on each line. Death . 1edical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial - transi sician/Medical AMENDED UNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 V Unknown þ 24b. Were autopsy findings available Completed 24a. Was an Records, s peen s prior to completion of cause of autopsy death? performed? this certificate has b I director, page 2 sh Yes No Yes 2 ✔ No 26 Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ Nursing Home 5 Residence 6 Other: Scene Hospital: ER/Outpatient 3 2 Inpatient this 1 Yes ۵ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After t funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2 ✓ Natural Pending To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie November 5, 2007 O.C.M.E.

State Registrar 111 Penn Street, Baltimore, MD 21201

COME

30. Name and address of person who completed cause of death (Item 23a)

2007

O 6

Zabiullah Ali, M.D.

Assistant Medical Examiner

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Nician 06 15 3,2007 Nevember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Tohns Hipkins nder 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 4-25- Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Hours 1□M 2 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show. Baltimore 1 Nes 2 No r 28a-f sh notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Completed by 3 ☐ Widowed 4 Divorced lac 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. De Not use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of B Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) Pather's Name (First, Middle, Last) Be and Mental I 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) onteia M. McDonald (Daughter t of Health : 3124 Department of Health Important: if Item 27 any injury or other tronce. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (3 Removal from State Baltimore 5 ☐ Other (Specify) permit. 21. Signature of Funera Survice Licence ne funeral Services Ba 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sudden **Physician** /Medical Examiner Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9□Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an page 2 s has autopsy performe certificate 2 No To the Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 [X]npatient ٩ 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🛮 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)

10 State

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

Shoemaker, 31. Date filed (Month, Day, Year) NOV 0 6 2007

29b. Signature and title of certifier

The Johns Haskins Hospital, Wo North Wolfe Street, Ballemore, Maryland 21287 32. Registrar's Signature

29c. License number

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	Certific	ate of Death	Reg. No	2001	33323
			Decedent's Name (First, Middle, Last)	- ,		Date of Death Month Da	y Year	3. Time of Death
	Physicia /Medic		Jehnifer n. J	ackson		Ochser 30	D 2007	9.40 B W
	Examin		a. Facility Name (If not institution, give street and number)	1.1.	ity, Town, or Location of Death	4c	. County of Death	
			2/1/1		Bellinore	O Data of Dinth	V/A	place (State or Foreign
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday) If Un Mont	der 1 Year If Under 24 Hrs. hs Days Hours Min.	8. Date of Birth (Month, Day, Year) 3-25-195	9 Ton	place (State or Foreign intry)
	Director	-	()70-12-9196 Usual Residence of Decedent	10		23 . 70	1 0 2.	
	land bw	1	10a. State 10b. County	10c. City, Town or Location	1			10d. Inside City Limits
	Mary -f sh	ţ	Md Baltimore	Klisters	town			1 Д¥es 2 No
	r 28e	Director	10e. Street and Number	10f.	Zip Code	10g. Ci	tizen of What Cou	intry?
	th wit		205 Delight Mead	ows Kd.	21136		14. Race - Amer	ioon Indian
	r dea	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	If Yes,	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	Black, White	
36	2 should be filed within 72 hours after death with the Maryland and Menth Hygiene. Is marked other Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	No 1 □ Ye	s 2 4 No Specify:		Specify: 3	ack
5-0036	hour tural		15. Decedent's Education	16a. Decedent's	Usual Occupation	16b. F	Kind of Business/I	ndustry
215	in 72 n "na Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or to the content of the conten	life. DO NO	f work done during most of work T use retired)	ang	11. 11.	_/
212	d with giene ar tha the I	mo.	12	Nurse	's Aide		1edica	1
b	al Hy I othe	Be (17. Father's Name (First, Middle, Last)		101	e (First, Middle, Maide	n Surname)	
yla	2 should be filed and Mental Hygie is marked other aumatic event, the	ဥ .	Uriah Popley	401 14 75 - 4 44	ress (Street and Number or Ru	ral Pauta Number City	Town State 2	in Code) 7//3/.
Maryland	2 sh and is m		19a. Informant's Name/Relationship (Type. Print)		1. 1 1 1	~ 1/1 'D	isterit	1 10 M 1
	1 and Health em 27 ther tu	1	Joseph Jackson husba 20a. Method of Disposition	20h Place of Disposition	Name of		ocation - City or	Town, State
altimore,	Pages nent of l int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crematory	Cemetery: 11-1	2-2007 12	Balto. 1	hd.
틒		1	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	22. Nam	te and Address Facility	. Funera		e P.A.
Ba	permit. Departimport Import any inj		Carlon C. Danda	1201	Uc Culloh S	Balto.	W. 212	17
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I	d the death. Do not enter the		or respiratory arrest,		Approximate Interval Between
870	Physician	ē į	Immediate Cause (Final disease or condition		steoscrona			Onset and Death
la e	/Medical		CI.	a consequence of):				
	Examiner		Sequentially list conditions. b.					-
	Sit 3d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequence of):				
	rtificate be executed ng physician and as the burial-transit	хап	that initiated events C.	a consequence of):				
68760,	sician buria							
89	ifficate g phy as the	Medical						
Вох			IF FEMALE: 23c. If yes, outcom 1 ☐ Live birth	e pf pregnancy 2 ☐ Fetal death 3 ☐ Ecto	pic pregnancy		23d. Date of de Month	livery Day Year
B	The law requires that the death ce tte has been signed by the attendi age 2 should be detached for use	Physician/I	in the past 12 months? 4□ Pregnant : 1□ Yes 2□ No 9□ Unknown	at time of death 5 ☐ Othe	er (specify)			
P.O.	nat the d by tl etach	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death	but not resulting in the underly	ring cause given in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?
	ires th signed	by	End Stage Renal Disco			1 ☐ Yes	2 No 3 P	robably 4 Munknown
Ö	requ been should	eted	Markerson			24a. Was an	24b. Were a	utopsy findings available
Rec	ne law has b ne 2 s	Completed	- Mpc kuson			autopsy performed	prior to death?	completion of cause of
a	n: Th ficate or, pay		25. Was case referred to medical		26. Place of De	1 Yes 2 1 ath (Check only one)	NO ILLIE	2/2/10
₹	s cert	o Be	examiner?	tient 2 ☐ ER/Outpatient 3	Other	lome 5 ☐ Residence	6 □Other (Sp	ecify)
0	Attending Physician: r death. ector: After this certifici	1-	27. Manner of Death 28a. Date of In	jury 28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	jury occurred	
ior	ath. pr: Aff	atjo	2 Accident investigation		1 ☐ Yes 2 ☐ No			2 - Court Number
Division or Vital Records,	or Atterde Directorin by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of in building,	njury - At home, farm, street, f etc. <i>(Specify)</i>	actory, office	28f. Location (Street City or Town, St	and Number or F ate)	sural Houte Number,
Ω	oital o urs aft eral D	S	29a. Certifier 1 Certifying Physician: To the bes	t of my knowledge death occ	urred at the time, date and place	e. and due to the cause	e(s) and manner a	as stated.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Check only one Check o	of examination and/or investi-	gation, in my opinion, death occ	curred at the time, date	and place, and du	ue to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier		29c. License number		Date signed (Mor	
ì	⊢ ≶ ⊢ ō		Balle, MD		0006613	7 0	U-Ser.	50, ws 7
	5			death (Item 23a) (Type, Print				
_			Amera Ethernsten, MD So	row Hospital or	15dhore, 240	of wisder	oure fr	121212
	St	ate		strar's Signature				

Jackson, M. Jennifer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

wrence Jones		State of Maryland / Departi 1-For State Certif	ficate of Deat			. No. 2007 3	553
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Death	3. Time of D	
edical Examii	ner	LAWRENCE DARNELL JONES			Month November	2, 2007 1511 h	rs
		Facility Name (if not institution, give street and number) John Hopkins Bayview Medical Center	4b. City, Baltir	Town, or Location of More	of Death	4c. County of Death	
Funeral	=	5. Social Security Number 6. Sex 7. Age (In yrs. last			er 24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birthplace (State	e or
Director		220-27-8783 1XM 2F 17	Yrs. Monti	ns Days Hours	Min. 03/18/	Foreign Country) MD)
<i>b</i>	Ì	Usual Residence of Decedent	own or Location			10d. Inside	City Limits
ow an		DAT	TIMORE			1 X Yes	2 No
ryland a-f sh	횽	MD BAL 10e. Street and Number		p Code	10	g. Citizen of What Country?	
he Ma 1 or 28 iffed a	Director	1138 STEELTON AVENUE		21224		USA	
with t ns 23a be not		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Deced	ent of Hispanic Ori	gin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - American Indian, E White, etc.	3lack,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene A in matural", or items 23a or 28a-f show any important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	Never Married 2 Married 1 Yes 2 X No				Specify: RT.ACK	
rs after ural", miner	百	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 1	6a. Decedent's Usua	No specify I Occupation (Give	kind of work done	Specify: BLACK 16b. Kind of Business/Industry	
72 hour r "nati	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of we	orking life. DO NOT	use retired)		
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	шb	9	STUDENT			SCHOOL_	
15-0 iled w Hygic d othe	ပိ	17. Father's Name (First, Middle, Last)			r's Name (First, Middle, M	laiden Surname)	
121 Id be f Mental narke event	o Be	LAWRENCE D. JONES, SR. 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addres		ENA McCOY mber or Rural Route Num	ber, City or Town, State, Zip Code)	-
MD 2 rd 2 shou alth and N m 27 is n	ř	ROWENA M. McCOY/MOTHER	I	ELTON AV		RE, MD 21224]
e, N I and Health item item		20a. Method of Disposition 20b. Pla	ace of Disposition (Na ematory or other place	ame of cemetery,	Date	20c. Location - City or Town, State	
Baltimore, Department of Hea Important: If ite		1 X Burial 2 Cremation 3 Removal from State	HELLS CEM	•	11-15-2007	BALTO., MD	
Baltir permit. I Departme Importa		31. gnature of Funeral Service Licensee		d Address of Facili		MORTON & SONS F.	H.,INC
		23b/Part I. Enter the disease, or complications that caused the death. D	1701-	-31 LAURE	NS ST. BALT	EMORE, MD 21217	nate Interval
Physician		failure. List only one cause on each line.		s or dying, such as	cardiac or respiratory arre	Detween	Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death) a. Gunshot wounds (2) to b.					
:		Sequentially list conditions, b					
	iner	if any, leading to immediate Due to (or as a consequence of):					
/ _ 1	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	:				
executed an and al - transit		d					
	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregna	ancy			23d. Date of delivery	
687 ertifica ding p e as th	an/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of deal	2 Fetal dea		oic pregnancy	Month Day	Year
Box 687 death certificathe attending ped for use as the	sic	1 Yes 2 No 9 Unknown	tn 5 Other (S	pecify)			
he he			sulting in the underlyi	ng cause given in l		obacco use contribute to the cause	_
, P.O.	d by					S 2 No 3 Probably 4	
Records, The law require ficate has been si	Completed				24a. Was auto	osy prior to completion	
Recol The law icate has page 2 sl	E E					death? 2 No 1 Yes 2	No No
tal Rection: The certificate ector, page	Bec	25. Was case referred to medical		Other	h (Check only one)	Dudden C Ohar	
of Vital ng Physician: After this certi	2	1 V Yes 2 No Inpatient 2 I	ER/Outpatient 3 28b. Time of Injury	DOA Other 4	Nursing Home 5	Residence 6 Other:	
n of Inding Ph. h. : After t	<u> </u>	27. Manner of Death 1 Natural 5 Pending Nov 2, 2007	1150 hrs	1 Yes 2	 Subject sho 	ot	
Division tal or Attendiins after death.	icat	2 Accident Investigation 28e. Place of Injury - At hor	me, farm, street, fact	ory, office building,		Street and Number or Rural Route I	Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) LDCal Stree	t		or Town, 1300 block o	f Ballard Way, Baltimore, MD	
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1			e, death occurred at	the time, date and	place, and due to the cau	se(s) and manner as stated. and place, and due to the cause(s))
To the within 2 To the complet	Medical	29b. Signature and title of certifier		29c. License numb		29d. Date signed (Month, Day, Y	
	2	1 Lexha Jel NO		O.C.M.E.		November 3, 2007	
_		30. Name and address of person who compléted cause of death (Item	23a)			<u> </u>	
2		Tasha Greenberg MD. Assistant Medical Exami		Street, Baltin	nore, MD 21201		
	tate	North transfer or a	re de de				
Regis		1000	ORIGINAL				
DHMH 17 Rev 1/	∠∪∪1	OCME	OKIOINAL				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 5:45 P ^M Mary Katherine Kerich 3, 2007 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4703 Broom Drive Olney
If Under 1 Year | If Under 24 Hrs. | Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F 76 Yrs. March 9, 1931 Director Missouri 389-28-3152 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show la or 28a-f sh 1 ☑ Yes 2 ☐ No Director Florida Bonita Springs 28a-f 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 25210 Gala Shields Circle 7 is marked other than "natural", or Items 23a traumatic event, the Medical Examiner must t 34134 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) filed withii Hygiene. Own Home Homemaker permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be C.J. Garding Mary J. Donahue ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25210 Gala Shields Circle, Bonita Springs, Florida 34134 Philip J. Kerich/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State November 9, Silver Spring, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home Rockville, Inc., 300 West Rockville, Maryland 20850 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Montgomery Avenue Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (produce or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the' 3S IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🔯 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. ð 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate has 1∐ Yes 2√√ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 □ Nursing Home 5 □ Residence 6 ☑Other (Specify)Residence 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA ို this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director: After t After Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and mariner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Wallmart, M.D. 9707 Medical Center Drive, Rockville, Maryland 20850 Segistrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 6 Registrar 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2,2007 Kelly Sr. 1:35 Folker November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dundalk Genesis Eldercare - Heritage Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 XM 2 □ F 65 Maryland 220-36-7245 November 13, 1941 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TNo Director Middle River Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? USA 21220 6517 Blackhead Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: 3 Widowed 4 □ Divorced White Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation Bus Driver 8 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary M. Folker William L.J. Kelly ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2557 Liberty Parkway, Dundalk, Maryland son William M. Kelly 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition 20c. Location - City or Town, State November Holly Hill Memorial 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Middle River, MD 5, 2007 ign ture of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 110 Sollers Point Road, Dundalk, MD. complications that caused the death. 23a. Part1. Enter the disease, shock, or heart failure. List Do Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Mann of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 MNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier eause of Heath (Item 23a) Type, Phint) 32. Registrar's Sig

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

	Physicia		1 - State Registrar Certificate of Death Reg. No 2007									355	33		
. Pł			1. Decedent's Name (First, Middle, Last) 2. Date of Death Month NoV • 5 2007									3. Time of Do	eath		
	Medic	aĺ	EMIL KORDISH										2007 ^r	8:00a	M
E;	xamin		4a. Facility Name (If not institution, give street and number) 2005 FALLS RD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)					PARKTON					4c. County of Death BALTIMORE		
	neral ector		5. Social Security Number 124-10-8610	6. Sex 1/2 M 2 □ F	7. Age (In yrs	s. last birthday) Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da 01/08	3/192	1 NEV	hplace (State or F juntry) VYORK	-oreign
land		-	Usual Residence of Decedent 10a. State 10b. County	,	10c. C	City, Town or Lo	ocation							10d. Inside City	Limits
he Mary	otified a	Director	MD BALT	PARKTO						10- Citi	1 ☐ Yes 2 No Citizen of What Country?				
th with the	tems 23a or 2 ner must be n	al Dir	10e. Street and Number 2005 FALLS RD				10f. Zip Code 21120					_	USA		
er dea		Funeral	11. Marital Status	Armed F	cedent Ever in Forces?	U.S. 13.	Was Deceder If Yes, specify	Vas Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto R			cify Yes or No Rican, etc.))~ 14.	14. Race - American Indian, Black, White, etc.		
irs aft	xamir	by F	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Glve Year or Dates:				1 ☐ Yes 2. No Specify:					Specify: WHITE			
72 hot	lical E	eted	15. Decede	t' nt's Education est grade completed	f)	i (Give	dent's Usual (done o	durina mos	at of workin	a	16b. Kind	of Business/	Industry	
within	e Mec	Completed	Elementary/Secondary (0-12)		(1-4or 5+) S	life.	DO NOT use LL ENC	retired	1)			E	NGINI	EERING	
Hygie	ent, th		17. Father's Name (First, Middle			011.	LD DIV			er's Name	(First, Middle			BRINO	
uld be Wental	rtic ev	To Be	ALEX KORDIS	Н					ANA	STAS	SIA T	IMKOV	A		
and 2 sho	nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show ry or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relation MYRA KORDISH	1	ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 FALLS RD PARKTON, MD. 21120.						Zip Code)				
Pages 1 and the Heart of He			20a. Method of Disposition 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c												
permit. Pages Department of	any injury o		21. Signature of Funeral Service	Licenses	-/	1	2. Name and HENRY	W.	JEN	ÍKTNS	5 & S(ONS C	0.111	1	
	ysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between										een		
Physi			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Onset and Death										eath		
/Med	dícal niner		resulting in death)	Due to	o (or as a conse	equency of):									
ZAUII		-	Se juentially list conditions, it any, leading to immediate	b. Due t	u (yı aşla conse	acquence of):	syr		11	/					·
) nted	ansit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	5 .	Atr	ral	tobo	re	lla	lur	<u> </u>				
entificate be executed	urial-tr		resulting in death) Last	Due to	o (or as a conse	equence of):				-					
icate b	the b	Medical		d											
To the Hospital or Attending Physician: The law requires that the death certificate hours after death.	the attending priyacian and the for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□ Ectopic pregnancy □ Other (specify)					23	23d. Date of delivery Month Day Year				
that t	should be detached										tobacco use	co use contribute to the cause of death?			
aquire	ad bluc	ed by								1 🗆	Yes 2	2√No 3 Probably 4 Unknown			
The law n	201	Completed										opsy ormed?	24b. Were a prior to death? 1 ☐ Yes	utopsy findings av completion of cau	vailable use of
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Physic of	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	မှ	1 Types 25 No No No No No No No No											ecify)	
dlng F		tion:	27. Manner of Death 1 Natural 5 Pend inves		28c. Injury at Work? M 1 Yes 2 No				I. Describe how injury occurred						
l or Atten after deat		Certification:	2 Accident Inves 3 Suicide 6 Could 4 Homicide deter	home, farm, st cify)	treet, factory, office 28f. Location				(Street and Number or Rural Route Number, own, State)						
Hospita 24 hours		Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
To the		Me	29b. Signature and title of certifier					29c. License number 29d.					. Date signed (Month, Day, Year)		
			John W. Bowrem I						020649 11/5/20				007		
	عا		30. Name and address of person JOHN BOWIE	M.D. 67	ouse of death (It			. Т	OWSC	ON, MI	D. 21	204.			
R	Sta legistr		31. Date filed (Month, Day, Yea		Registrar's Sig		nei								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death and Year Day **Physician** MELVIN MORRIS KATZ Jovem per 20C /Medical 4a. Facility Name (If not institution, giverstreet and number 4b. City, Town, or Location of Death 4c. County of Death Examiner MOU N/A If Under 24 Hrs. 8. Date of Birth (Month, Pay Year) 02/14/1922 Birthplace (State or Foreign Country) MD **Funeral** Months 213-16-4789 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 □ No **Funeral Director** MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 7111 PARK HEIGHTS AVENUE, APT. #302 21215 USĀ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) CPA ACCOUNTING permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY KATZ STRINER GOLDIE ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8004 SUNSTONE CIRLCE, BALTIMORE, MD DAVID KATZ / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/04/2007 BETH TFILOH CONG. BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 WK disease or condition resulting in death) /Medical greater than **Examiner** greater than Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed greater than Division or Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ a No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 1□ Yes 212 No or Attending Physician: 25. Was case referre o medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 1 ☐ Yes ဥ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: . 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) lovember 2,2007 30. Name and address of pur n who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Known as Melvin Kat

32. Registrar's Signature

Mosphal

Physician Examiner Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed and burial-tran attending physician the as nse for signed by the a page 2 should certificate this After ! death.

Physician

/Medical

Examiner

Funeral

Director

show

an "naturai", or items 23a or 28a-f show Wedical Examiner must be notified at

filed within 72 hours after

Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygid Important: if item 27 is marked other any injury or other traumatic event, #

/Medical

Examine

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

Maryland 21215-0036

Baltimore,

Director

Funeral

þ

Completed

To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the

State Registrar

+Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chardin 7812

Dalewood Rep Sta 100

2001 71061

31. Date filed (Month,-Day,

4 ☐ HomicIde



DHMH 17 Rev 1/2001

Ferne M. Levit State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Month Day November 3, 2007 1200 hrs Medical Examiner Ferne Levit 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 221 Booth Street Montgomery Gaithersburg 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) **Funeral** Foreior Days Hours Director 191-36-6533 Country) PA 63 OCT 22 1944 М 2 X F Usual Residence of Decedent 10a, State 10c, City, Town or Location 10d. Inside City Limits Yes 2 X No 28a-f show MD Montgomery Gaithersburg death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 221 Booth Street, Apt. 417 20878 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes hours after If Yes, Give Year Widowed 4 X Divorced 1 Yes 2 X No specify: Specify: White ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) other than the Medical 21215-0036 5+ Teacher Public School 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Sumame) Be David Melenson event Frances UNK ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Alexandra R. Levit - daughter 828 Clarence Avenue, Oak Park, IL20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Baltimore, MD Other Specify. Metro Crematory, Inc. 11/06/2007 Donation 5 Cremation Society of Maryland, 299 Frederick Road, Baltimore 21. Signature of Funeral Service Licensee Steven H. Williams Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Intraoral gunshot wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED AMENDED The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 ✔ No 9 Unknown Unknown by the Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ σ, Yes 2 ✔ No 3 Probably 4 Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? death? page ✓ Yes 2 No ✓ Yes No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene this 1 V Yes 28a. Date of Injury (Month, Dey, Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot self Natural **FOUND** within 24 hours after death.

To the Funeral Director: Pendina 1 Yes 2 ✔ No in by the Nov 3, 2007 1145 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 221 Booth Street, Gaithersburg, MD (Specify) Woods Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 4, 2007 30. Name and address of person who completed cause of death (Item 23a) 3 Assistant Medical Examiner Tasha Greenberg MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 7-08565 State of Maryland / Department of Health and Mental Hygiene Myra Judith Lemus Certificate of Death 1- For State Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) Month Day November 3, 2007 Physician/ Medical Examiner Mayra Judith Lemus 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Greater Baltimore Medical Center Towson 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) ial Security Number **Funeral** Months Days Hours 807-70-9131 Director 1977 30 15 1 M 2XF Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County MD Baltimore Cockeysville death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21030 4 E. Deepwater 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 X Married Yes 1 X Yes 2 No specify: Guatemalan Specify: Hispanic t. Pages I and 2 should be filed within 72 hours after truent of Health and Mental Hygiene.
riant: If item 27 is marked other than "natural", of or other traumatic event, the Medical Examiner m If Yes, Give Year 4 Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Construction MD 21215-0036 n/aPainter 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herlindo Arcvalo Hilda Folgar Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elden Lemus/husband 4 E. Deepwater, Cockesyville, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place)
Cuatemala
Quatemala Burial 2 Cremation 3 X Removal from State Guatemala permit. Pages
Department of
Important: I 11/12/07 Other Specif Donation 5 22. Name and Address of Facility 21. Signature of F Lemmon Funeral 10 W. Padonia of Dulaney Valley Timonium, MD 2109 Home Rd. Michaela ocomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician 'edical failure. List only one cause on each line a. Complications of alcohol abuse Immediate Cause (Final disease iminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit 5,20b,c per fh g873 11-6-07 vt Physician/Medical X UNPENDED **X** AMENDED physician the burial -#1_23a_27_perME_o874 that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregna IF FEMALE: Month Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown Ď Completed 24b. Were autopsy findings available 24a. Was an this certificate has been I director, page 2 should autopsy performed? Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death Be Division of Vital Other₄ Residence 6 lospital: Nursing Home 5 Inpatient 2 V ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2 No 1 X Natural Pending Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) Suicide determined within 24 hours at Medical

28f. Location (Street and Number or Rural Route Number, City Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number November 4, 2007 O.C.M.E. 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner 32 / Registrar's Signature **ORIGINAL** OCME

2007 35537 3. Time of Death

2134 hrs

Country Guatemala

10d. Inside City Limits

Yes 2 X No

Guatemala

Approximate Interval

Between Onset and

Death

Year

Day

death? 1 🗸 Yes

Other

prior to completion of cause of

Foreign

State Registrar

LIK

29b. Signature and title of cert

30. Name and address of person

31. Date filed (Month, Day, Year)

Jack Titus MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3, 2007 **Physician** Geneva Farr Larson November 10:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Brighton Gardens North Bethesda Montgomery 8. Date of Birth (Month, Day, Yea April 24, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 X F 93 Director 216-44-6861 1914 Utah Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery North Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5550 Tuckerman Lane United States 20852 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No White Specify þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National Institutes Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant of Health 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental H Aaron L. Farr Ella May Bingham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health in Item 27 I Julianne L. Middledorf/Daughter 18307 Bluebell Lane, Olney, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State November 9. Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 2007 22, Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service bicerse U. tima Millian M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction 4 hours /Medical Due to (or as a consequence of): Examiner Hypercholesterolemia 12 years Sequentially list conditions, Due to (or as a nonsequence of) Examine day, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-transit Diabetes Mellitus, Type II 20 years and Due to (or as a consequence of) physician Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔀 No the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 TYes 2 No 1□ Yes 2X No director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 X Natural Injury 5 | Pending 1 ∏ Yes 2 ☐ No М death. investigation 2 ☐ Accident To the Hospital or Attency within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

death v

filed within 72 hours after

Maryland 21215-0036

altimore,

Vital Records,

Division or

Physician:

State Registrar

Medical

31: Date filed (Month, Day, Year)

(Check only

20b. Signature and title of certifier

James F. McMurray,

one)

Jr., M.D. 32 Registrar's Signature

ame and iddress of person who completed cause of death (Item 2, a) (Type, rint)

11119 Rockville Pike, Suite 409, Rockville, MD 20852

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

D30844

29d. Date signed (Month, Day, Year)

			For State Registr <i>a</i> r		State of	Maryland		ertificate of			Reg. No.	0000	35539
	Physicia		1. Decedent's Name (First, Mi			iane La	Fonta	a		2. Date of De Month Novemb	eath Day	, 2007	3. Time of Death 12:30 A M
	/Medic Examin		4a. Facility Name (If not institu	ıtion, give	street and num			4b. City, Town,	or Location of De		4c.	County of Death	
			Suburban Hos 5. Social Security Number	spita 6. Se		7. Age (In yrs. l	ast birthday		ethesda I If Under 24 H	rs. 8. Date of Bir		Montgome 9. Birthi	
	Funeral Director		213-25-5342 Usual Residence of Decedent	1[_M 2 ⊠ F	40	Yrs.	Months Days	Hours Mi	n. 8. Date of Bir (Month, Da	7, Year)	66 New	place (State or Foreign ntry) Y York
	yland how at		10a. State 10b. Cou			10c. City	, Town or I	_ocation					10d. Inside City Limits
	e Mai 8a-f s	ctor	Maryland Mon	tgome	ery			Bethesda					1 ☐ Yes 2 ☒ No
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number 10305 Chesh	ire 7	errace			10f. Zip Code	20814		Uni	izen of What Cou ted Stat France	es and
ne Diane 0030 Mand 21215-0036	_ 0 0	þ	11. Marital Status 1 ☐ Never Married 2 🔀 1 3 ☐ Widowed 4 ☐ Divor	1	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	2 X No e	5. 13	. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 🔀 No		(Specify Yes or No erto Rican, etc.))-	14. Race - Ameri Black, White, Specify:	
17.6 15-0	"natur	Completed	15. Dece (Specify only hi	dent's Ed	ucation de completed)	I,	16a. Dec	edent's Usual Occu re kind of work done DO NOT use retire	pation during most of v	vorking	16b. K	ind of Business/Ir	ndustry
2001 21	withir lene. • than	dwo	Elementary/Secondary (0-1	2)	College (1 5-	-4or 5+) 	me		acher			Educ	cation
100 P	d 2 should be filed within 72 h th and Mental Hyglene. 7 is marked other than "natu traumatic event, the Medical	Be C	17. Father's Name (First, Mid	. ,					1	lame (First, Middle			
Z+Z	d Ment d Ment marked martic e	မှ	Edouard Mo 19a. Informant's Name/Relat		vne Print)		19h Ma	iling Address (Stree		ine de Co			n Code)
T. d.	alth and 27 is may be traumant.		Jean La Font					05 Cheshi			nesda	a, Maryla	and 20814
Telegie de la constant de la constan	permit. Pages 1 and 2 De artment of Health a im ortant: If item 27 is an Injury or other trai		20a. Method of Disposition 1 ☐ Burial 2 【Cremati 4 ☐ Donation 5 ☐ Other	on 3 🗆	Removal from S	State Mor	lace of Dis	position (Name of rematory or other place ry ium, Inc	37	Date vember 7,	20c. Lo	ocation - City or T hesda,M	own, State
よ温	pe mit. F De aartm Im ortar an Injui		21. Signature of Funeral Ser		-		loo	22. Name and Addi Robert A.	ess of Facility Pumphre	ey Funera	1 Hc	me/Bethe	esda-Chevy Se, Inc. 14-3501
L Corporation			23a. Part1. En er he disease shock, or leart failure.	e, or comp List only	olications that cone cause on e	MOO aused the death ach line.	Do not e	/55/Wisc	onsin Aving, such as card	re., Bethe diac or respiratory	esda, arrest,	MD 2081	Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		a. Myco	cardial	Infa						Onset and Death
	Examiner				Due to (or as a consequ	uence or):						
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2	Due to (or as a conseq	uence of):						
ó	ficate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) Last		C. Due to (or as a conseq	uence of):						
68760,	cate be physicia the bu	edical			.d								
. Box	death certifi e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	t	1□Live b	come pf pregna sirth 2 Feta lant at time of d	I death	3 □Ectopic pregnan 5 □ Other (specify)	су			23d. Date of deli Month	very Day Year
ds, P.	ires that the de signed by the d be detached t	þ	Part II. Other significant cor	nditions o	ontributing to de	eath but not res	ulting in the	underlying cause g	iven in Part I.		tobacco Yes 2		the cause of death?
Division or Vital Records, P.O	The law requir e has been si age 2 should t	Completed								24a. Wa aut per 1□ Yes	opsy formed?	death?	topsy findings available completion of cause of
ital	sician: The certificate h	BeC	25. Was case referred to me examiner?	dical					26. Place of	Death Check onl		0 1 1 1 1 1 6 3	2010
or V	Physic this ce	은	1 ☐ Yes 2 ☑ No				ER/Outpat	IEIIL SLIDON		g Home 5 ☐ Re			cify)
o no	nding Pt tth. r: After th e funeral	ation:	27. Manner of Death 1 Natural 2 Accident	ending vestigation	,	of Injury th, Day Year)	28b. Time Injur	y W	ury at ork?]Yes 2∏No	28d. Describe	e now inju	ury occurred	
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	Certification:	3 Suicide 6 □ Co	ould not be termined	28e. Place buildi	of injury - At he ing, etc. <i>(Specil</i>	ome, farm,	street, factory, offic	Э	28f. Location City or T	(Street a	and Number or Ru te)	iral Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by	Medical C	29a. Certifier 1 Certifier (Check only one)	tifying Ph lical Exar	niner: On the b	e best of my kno asis of examina ner stated.	wledge, de ation and/o	eath occurred at the r investigation, in m	time, date and p opinion, death o	lace, and due to the	e cause(e, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of co	Irtifier A	Sher)		29c. Lice	nse number	49	29d. D	ate signed (Monti	h, Day, Year)
	21		30 Name and address of be	rson who	Haa	se of death (Iter	860	00 Old Geo	rgetown	Road, Be	ethes	sda, Mar	yland 20814
	Sta Regist		31. Date filed (Month, Day,		32. F	Registrar's Signa	ature						
	- Inagist	004	NOV 0	200	PHAN	100 10	1						

DHMH 17 Rev 1/2001

			For State Registrar		State o	of Mary			rtment of H		and M		giene Reg. No	711	07	355	40
灰	ē		Decedent's Name	(First, Middle, Las	st)							2. Date of De			Vaar	3. Time of E	Death
	Physici Medie		BETTY LOU	ISE LONG								Month 10	31		Year 2007	10:00)A M
	Examir		4a. Facility Name (If r	not institution, give	street and nu	ımber)			4b. City, Town, or	Location o	f Death				of Death		
			214 HANCE						LINTHIC					NE A	RUND		
, S.	Funeral Director		5. Social Security Nur 213-30-74	11 1	ex □M 2 <mark>M</mark> F	7. Age (Ir	yrs. last birt	rhday) Yrs.	If Under 1 Year Months Days	If Under a	Min.	8. Date of Bir (Month, Da 8/12/1	932		9. Birthp Court	place (State or ntry)	Foreign
	aryland show	2		10b. County ANNE ARU	NDFI.	10	c. City, Town								1	0d. Inside City	
	he M 28a-f otifle	Director	10e. Street and Numb				LLMIII.	LCOI	10f. Zip Code				10a Cit	izon of V	What Cour		
	with a or the r		214 HANCE						21090				U.S		viiai Coui	itiy:	
	ns 23	Funeral	11. Marital Status	711101	12. Was Dec	edent Ever	r in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Orig	gin? (Sp	ecity Yes or No			e - Americ	can Indian,	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Menteal Examiner must be notified at	by Fur	1 ☐ Never Married		Armed F 1 ☐ Yes If Yes, G Year or D	2 /⊡ ANo ive			Yes, specify Cuba	an, Mexican Specify:	ī, Puerto	Rican, etc.)		Specify	ok, White, /: WHI!		
9	2 hou	ted	(0)	15. Decedent's Ed	lucation		16a.	Deced	ent's Usual Occup	ation			16b. K	ind of Bu	usiness/Ind		
21215-0036	within 7 jene. r than "n	Completed	Elementary/Second 12	y only highest gra dary (0-12)		(1-4or 5+)	IM)	life. L	kind of work done of NOT use retired I / EXPORT	auring mosi 1)	t ot work	ing	BRO	KERA	GE		
	il Hygi other ent, tl	Be C	17. Father's Name (F	irst, Middle, Last)						18. Mothe	r's Name	e (First, Middle	, Maiden	Surnarr	ne)		
Maryland	uld be Mental Irked o	To B	RALEIGH W	ILLIAM A	LLISON					LOUI	SE N	MILLER					
lar)	2 should b and Menta Is marked raumatic e		19a. Informant's Nan	ne/Relationship (Type. Print)				g Address (Street								
	Health Health tem 27 I		MR. THOMAS		SON				PALMETTO	COURT							
Baltimore,	Pages 1 a ment of Hea ant: If item ury or othe		1 Aburial 2 Cremation 3 Removal from State										Oc. Location - City or Town, State				
Balt	permit. Pages Department of Important: If i any Injury or once.		21. Signatur of the Service Licensee 22. Name and Address of Facility SINGLETON FUN 1 2ND AVE. S.W., GLEN BURNIE,									MERAL & CREMATION		N			
	5		28a art1. Enter the	28a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to ras a consequence of):										Onset and D	eath			
	ed sit	iner	Sequentially list conditions, leading to immoduse. Enler Underly Cause (Disease or in that initiated events	ditions, nediate	Due to	(or as a co	nsequence o	of):									
oʻ	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) La	st	cDue to	(or as a co	nsequence o	of):									
68760,	ificate be g physici as the bu	edical			d												
.O. Box	The law requires that the death certific to has been signed by the attending p tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonthee		birth 2 [nant at tim	Fetal death		Ectopic pregnancy Other (specify)	/					te of delive	*	ear
JS, P.	ires that signed b	þ	Part II. Other signific	~ 1	•	death but no	ot resulting in	the ur	derlying cause giv	en in Part I.			tobacco	use cont	_	he cause of de bably 4 ∐U	
Ö	w require been si	eted	MAR	perter	10(~									1			
Records,	The law ate has t page 2 s	Completed										24a. Was auto perf 1 Yes	opsy ormed?		prior to co death?	opsy findings a impletion of ca 2 \square No	vailable use of
Vital		BeC	25. Was case referre	ed to medical						26. Place	of Deat	h (Check only			50		
or <	dii jys	TO E	1 ☐ Yes 2 ☑ N	0		Inpatient	2 ER/Ou	tpatien		4 □ Nu	rsing Ho	me 5 Res	idence	6 □Oth	ner (Specil	fy)	
	Jing After fune		27. Manner of Death Natural	5 Pending		of Injury onth, Day Ye		ime of njury	28c. Injur Wor M 1 🗆	yat k? Yes 2 □ l	No	28d. Describe	how inju	ry occur	red		
Division	or Attending after death. Director: After in by the funer	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigation 6 Could not be determined	28e. Plac	e of injury - ding, etc. (3	At home, fai Specify)	rm, stre	eet, factory, office	res z	-	28f. Location (City or To	(Street ar own, State	nd Numb e)	er or Rur	al Route Numi	ber,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co			ysician: To the land mai	e best of m basis of ex	ny knowledge amination an	, death d/or inv	occurred at the tire estigation, in my contract	me, date an opinion, dea	nd place, ath occur	and due to the red at the time	e cause(s	s) and ma nd place,	anner as s and due t	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and ti	tle of certifier					29c. Licens D9 Print)	e number	13		29d. Da	ate signe	d (Month,	Day, Year)	χ 7
,	7		30. Name and address		completed cau	se of death	ı (Item 23a) (Туре,	Print)			_	, - 5 0	14	07	17	•
l	Sta	ite	31. Date filed (Month	oda IV n, Day, Year)	MC)	Registrar's	Signature	VCe	Murgla	ead(_OT	2000	le	M		100	
	Registi		NC	JV 0 6 20	07 46	September 1	15.										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08447 State of Maryland / Department of Health and Mental Hygiene Manuel Lopez 2007 35541 Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 30, 2007 1850 hrs Medical Examiner MANUEL LOPEZ c. County of Death 4b. City, Town, or Location of Death 4a. Fadlity Name (if not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** ForeignGUATEMALA Days Months Hours Director 2 F M XX Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State Yes 2 No s 23a or 28a-f show 28a-f shov ANNE ARUNDEL GLEN BURNIE with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8909 JEFFMAR DR. **IATEMALA** 21061 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ם 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. nt of Health and Mental Hygiene.
1: If item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner must be. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funer Armed Forces? 2 XX Married Never Married Yes 2XX No 1XX Yes 2 No specify: GUATEMALAN Specify: HISPANIC If Yes, Give Yaar Divorced ъ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 21215-0036 LANDSCAPING HNK LABORER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LOIS LOPEZ SAVINA NAJARRO Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) CLEN BURNLE FRANCISCO CONTRERAS JEFFMAR DR. 1061 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 XXBurial 2 Cremation 3XX Removal from State **GUATEMALA** Donation 5 Other Specify. unk unk 22. Name and Address of Facility omture of Funeral Service Licensee, FINK FUNERAL HOME, P.A. FINK M01148 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Between Onset and **Physician** one dause on each line. Death /Medical a Head injuries complicating acute ethanol intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and -Physician/Medical X UNPENDED AMENDED 27,28a-f. perME, 2873, 11/30/07 TT To the Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown ģ ۵. Completed 24b. Were autopsy findings available Records, 24a. Was an has been s prior to completion of cause of autopsy performed? death? 1 V Yes ✓ Yes 2 page certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be of Vital Other: Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 this 1 V Yes ۵ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury After 27. Manner of Death 1 Yes 2X No Natural Division 5 Pending Fnd 11:45 am death. FNd 10/28/2007 the Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc in by within 24 hours after To the Funeral Dire 6 X Could not be 3 or Town, State) Suicide determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medica and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 31, 2007 O.C.M.E. (lups 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month, Pay 32. Registrar's Signature State 6 Commence. Registra

DHMH 17 Rev 1/2001 OCME 2006 07-08493 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lois C. Levy State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 1, 2007 Medical Examiner LOIS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Cecil Route 1 at Greenmount Road Rising Sun 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Director 187-28-4946 70 06/12/1937 1 M 2 X F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show PΑ MONTGOMERY KING OF PRUSSIA ges I and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. Examiner must be notified at once. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10301 VALLEY FORGE CIRCLE 19406 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Married Yes Yes, Give Yea 4 X Divorced Yes 2 X No specify: Specify. ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) tant: If item 27 is marked other than " ltimore, MD 21215-0036 HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname Be **BROWN** ARDELLE 19a. Informant's Name/Relationship (Type, Print) ARTHUR KAPLAN / BROTHER-IN-LAW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 X Removal from State R00 SEVELT MEMORIA [0/06/2007 Donation 5 Other Specify: 22. Name and Address of Facility Signature of Fuperal Service 8900 REISTERSTOWN Physician Part I. Enter the disease, or failure. List only one cause on each line /Medical a. Multiple Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit ca X AMENDEDO, perFh, G873, UNPENDED Physician/Medi 11/6/07 TI 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 V No 9 Unknown Unknown icate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Þ Completed 24a. Was an autopsy certificate has performed? ✔ Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Other₄ ER/Outpatient 3 DOA Inpatient 2 After this 1 V Yes ဥ Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Nov 1, 2007 Natural 1249 hrs Yes 2 V No Pendina 2 🗸 Accident Investigation

19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)
1420 LOCUST STREET - PHILDADELPHIA, PA 19102 PA 19102 20c. Location - City or Town, State TREVOSE, PA SOL LEVINSON & BROS.. INC. PIKESVII complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Between Onset and Death Division of Vital Records, P.O. Box 68760, 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? Yes 2 V No 3 Probably 4 24b. Were autopsy findings available prior to completion of cause of death? Nursing Home 5 Residence 6 🗸 Other: Scene 28d. Describe how injury occurred Driver auto auto collision filled in by the 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Could not be or Town, State) Route 1 at Greenmount Road, Rising Sun, MD determined (Specify) Major Road / Highway Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 2, 2007 30. Name and address of person who completed cause of death (Item 23a) 10 Pamela E-Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (MR) egistrar's Signatu State Registrar DHMH 17 Rev 1/2001 **ORIGINAL OCME**

2007

White, etc.

35542

3. Time of Death

1258 hrs

10d. Inside City Limits

Yes 2 X No

Country) PA

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2, 2007 6:50 Beryl McDonough November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville 315 Montrose Avenue If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🕅 F 78 Oct. 29, 1929 Maryland Director 213-26-9048 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 315 Montrose Avenue 21228 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Artist Arts 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ John T. Scheffer Emma Engel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 7112 Woodbine Road; Woodbine, MD 21797 Lisa Zimmerli - Daughter permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-6-2007 St John's Cemetery Ellicott City, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue: Catonsville. MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic malabsorption 9 years **Physician** /Medical Due to (or as a consequence of) Examiner oderma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Mixed connect the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by page 2 should be OSTEUNOVOSIS 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1 Yes 2 No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 | Inpatient After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Watural 5 Pending investigation n 24 hours after death.

le Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Fune completely fi (Check only one) and manner stated. To the within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed ause of death_(Item 23a) (Type, Print) West Redwood St. Baltimore, MD 1d 31. Date filed Month, Day, 22. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 0 6 2007

			State of Maryland / Dep State of Maryland / Dep Registrer State of Maryland / Dep	artment of Health and M rtificate of Death		ene 007	35544
	Physicia	an	Decedent's Name (First, Middle, Last) Eleanor Myers		2. Date of Death Month November 2	2, 2007 Yeer	3. Time of Death 4:20 P M
	/Medid Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	4.20 1
			Kensington Nursing and Rehab	Kensington		Montgon	nery
	Funeral Director		5. Social Security Number 216-44-6869 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 85 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) June 23,	(ear) 9. Birthpi Count 1922 New	lace (State or Foreign try) York
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10	0d. Inside City Limits
	Mary f sho	to	Maryland Montgomery Kensing	ton			1 ☐ Yes 2 🔀 No
	th the	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Coun	try?
	ath wi		4419 Everett Street	20895		nited State	
396	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked tother than "natural", or Items 23s or 28s-f show aumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WWII If Yes, Give Year or Dates: Korea	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, of Specify: Wh	
Maryland 21215-0036	nin 72 ho In "natur Madical I	Completed	(Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ring	6b. Kind of Business/Inc	fustry
2	ed with	Com	4	Nurse		U.S. Gover	nment
and	I be file	Be	17. Father's Name (First, Middle, Last) Glenford Myers		e (First, Middle, Ma e Wells	aiden Sumame)	·
<u> </u>	should nd Mer marke matic	은		ing Address (Street and Number or Rur		City or Town, State, Zip	Code)
Z Z	nd 2 salth ar			Market Street, Sau			12477
altimore,	ges 1 and 2 should t of Health and Men If item 27 Is marke or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetary, cre	matani ar athar alagal	Date 20	Oc. Location - City or To	wn, State
Ĕ	Pagiment tant: h		`4 □Donation 5 □Other (Specify) Montgomery	Crematorium 200		ethesda, Ma	ryland
Ball	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other traingne.		21. Signature of Funeral Service Licenary M01173 7	2. Name and Address of Facility obert A. Pumphrey Fund 557 Wisconsin Avenue,	eral Home, Bethesda,	Bethesda-Che Maryland 200	vy Chase, Inc 814
	/Medical Examiner		23a. Part1. Enter the disease, or complications that daused the death. Do not enshock, or heart failure. List only one cause an each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	ater the mode of dying, such as cardiac			Approximate Interval Between Onset and Death
		dicai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):				
O. Box 687	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medic		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
ds, P.	luires tha signed I	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to th 2 ÛNo 3 ☐ Prob	ne cause of death?
Vital Records,	The law require sate has been si page 2 should b	Completed			24a. Was an autopsy perform	prior to cor death?	psy findings available mpletion of cause of
Vita Vita	Physiclan: r this certifica ral director, I	Be	25. Was case referred to medical examiner?	Other	th (Check only one		
o	Physic this oral direction	1: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	ome 5 Resider 28d. Describe hov	nce 6 Other (Specify w injury occurred	()
on	nding ath. r: Afte e fune	atlor	1 Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1☐Yes 2☐No			
Division of	To in-prospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
	-rospit 124 hours e Funera letely fille	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea and manner stated.				
	To the To the To the Formplete	Me	29b. Signature and title of confier	29c. License number		d. Date signed (Month,	
2	ot		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)			
::3	Sta Registr		Truong Bao, M.D. 9715 Medical Cen 31. Date filed (Month, Day, Year) NOV 0 6 2007	ter Drive #201, Ro	ockville,	Maryland 2	.0030
		* P . E .	INOV				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

and manner stated.

 $M \cdot 1)$

1. Decedent's Name (First, Middle, Last)

23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ► No 24a. Was an autopsy performed? 2 **X**Vo 26. Place of Death (Check only one) Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 **Exertifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 00062172 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATYAL, M.D; 1604 MARKET ST POLOMOKE CITY MD 32. Registrar's Signature

2. Date of Death

November

Min.

8. Date of Birth (Month, Day, Year) 05-25-1915

Ridgely, MD

Date

3. Time of Death

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1 ☐ Yes 2 No

2007

Somerset

10g. Citizen of What Country?

U.S.A.

Specify: White

Own Home

20c. Location - City or Town, State

21061

Approximate Interval Between Onset and Death

16b. Kind of Business/Industry

14. Race - American Indian, Black, White, etc.

4c. County of Death

3:45 A M

To the Hosp within 24 ho To the Functional

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 0 6

VINCENT MC GTNN/5S Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		Pleas	se Type or Prin							_	
		For State Registrar	State of Ma	aryland /	-	irtment of H <i>tificate of L</i>		/lental Hy		0007	05516
- 6		Registrar 1. Decedent's Name (First, Middle,	Last)		001	incate of L		2. Date of De		2001	3. Time of Death
Physicia /Medica	n al	Vincent	С.	Мс	Ginn			Napph		2 2007 County of Death	8.50 A. M.
Examine	er	4a. Facility Name (If not institution,				4b. City, Town, or					
Funeral		Baltimore Washi 5. Social Security Number	ngton Med. 6. Sex 7. Age	Center e (In yrs. last b	irthday)	Glen B	If Under 24 Hrs.	8. Date of Bir	rth	nne Arun	place (State or Foreign
Director	-	719/16/3196 Usual Residence of Decedent	1∏M 2□F 9	0	Yrs.	Months Days	Hours Min.	Dec. 1	6, 1	916 00	Washington
/land ow at	}	10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
e Man	cto	MD Anne Ar	undel	Mi1	llers	sville					1 □ Yes 3, T.No
or 28	Director	10e. Street and Number				10f. Zip Code			Ū	tizen of What Co SA	untry?
eath v	Funeral	655 Gearing (12. Was Decedent	Ever in U.S.	13. V	21108 Was Decedent of Hi	ispanic Origin? (Si	pecify Yes or N		14. Race - Amei	rican Indian,
Irs a	ह	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?			Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 212 No	n, Mexican, Puert	o Rican, etc.)		Black, White Specify: Wh	e, etc. iite
d within 72 ho giene. ir than "natur the Medical	Completed	15. Decedent' (Specify only highes Elementary/Secondary (0-12)		5+)	(Give life. L	tent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor f)	king		and of Business/	·
e filed withi al Hygiene. I other than vent, the M	S	12 17. Father's Name (<i>First, Middle, I</i>	(ast)	F	Railı	road	18. Mother's Nan	ne (First, Middle		Railroad	
d be filed ental Hyg ked othei c event,	To Be	James	•	inniss			Hele				Govern
es 1 and 2 should be fi of Health and Mental H fitem 27 is marked of ir other traumatic even		19a. Informant's Name/Relationsh Margaret McMorn				ng Address (Street a					Zip Code)
es 1 a of Hee		20a. Method of Disposition XIX Burial 2 □ Cremation	3 □Removal from State	ceme	terv. crer	sition (Name of matory or other place	ce)	Date	1	ocation - City or	
Pag ment ant: I ury o		4 □ Donation 5 □ Other (Sp	pecify)	Mt.		vet Cemet			Was.	hington 	DC
permit. Depart Import any Inj once.		21. Signature of Fune al Service I	_icensee -	MOIY		2. Name and Addre Singleto					
Physician /Medical Examiner	er	23a. Part1. 3 rte/ the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as	d the death. Do	e of):	er the mode of dyin	e. SW C1 19, such as cardiac Whole Ware SC CALLED A	or respiratory	arrest,		Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):									
the death ce / the attend ched for use	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal dea		□Ectopic pregnanc □ Other (specify) _	y 		livery Day Year		
quires that the de n signed by the a uld be detached f	by	Part II. Other significant condition	ns contributing to death b	out not resulting	g in the u	inderlying cause giv	ven in Part I.		tobacco	. A	o the cause of death? robably 4 ☐Unknown
The law requinite has been si	Completed								opsy formed?	prior to death?	utopsy findings available completion of cause of
ctor, p	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only	one)		
Physic this c	မ	1 Yes 21 No	Hospital: 11 Inpati		Outpatie	nt 3□DOA Oth	4 □ Nursing i	Home 5 ☐ Re		6 ☐Other (Spe	ecify)
ding I h. After funer	tion:	1 Natural 5 Pendin 2 Accident investig	g (Month, Da		Injury	Wor	rk? Yes 2∐No	200. Describe	e now my	ary occurred	
I or Atten after deat Director:	Certification:	3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of in	jury - At home, tc. (Specify)	, farm, st	reet, factory, office		28f. Location City or T	(Street a own, Sta	and Number or R te)	ural Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifyir edical	ng Physician: To the best Examiner: On the basis of and manner s	of examination	dge, deat and/or in	th occurred at the ti nvestigation, in my	ime, date and plac opinion, death occ	e, and due to the curred at the tim	ne cause(e, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifie	r			29c. Licens	se number	,	29d. D	ate signed (Mon	th, Day, Year)
1		1 Section	N.	Y)		104	37//	5-	NOV	mber	22007
2		30. Name and a dress of person	who completed cause of 30	ASSIT	a) (Type,	Dave,	Glen B	imi	۷.	MD.	2061.
Sta	ite	31. Date filed (Month, Day, Year)	32. Begist	tray's Signature	A	cartio					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** <u> 2007</u> vovember /Medical 4c. County of Death cility Name (If not institution, give street and number) Town, or Location of Death Examiner ecou TIMOre If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign last birthday) **Funeral** 1 M 2 ☐ F Days South Carolina Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 Ves 2 No **Funeral Director** more Maryland 10g. Citizen of What Country and Number 10f. Zip Code ns 23a or Was Decedent Ever in U.S. Armed orces th and Mental Hygiene.
7 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed orces Yes 2 No Yes, Give Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 2No 1 ☐ Yes þ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. NO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) hore 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Fadden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar important: if item 27 is any injury or other trauonce. Her. Napoleon 10 Mb Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/2007 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 21216 Vosth 23a. Part / Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) endogevernla **Physician** /Medical Due to for as a consequence of): Examiner Disean Signature of the state of the s Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has b autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **- N**o 2 ER/Outpatient 3 □ DOA 1 TYes Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 5 Pending investigation s after dec. rai Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD DZIY64 11150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENTAW St Ente 308 BALTIMORE HMI 82(N 2110

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #18.perFH.g873, 11/6/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 2007 1:00P ROSE MARKS G /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE MILFORD MANOR NURSING HOME BALTIMORE 9. Birthplace (State or Foreign Country) (In yrs. last birthdav) Jnder 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** 10/24/1907 1 □ M 2 🔽 F Yrs. 215-05-0862 100 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 □Yes 2 □ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 U.S.A. 6606 EDENVALE ROAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No WHITE Specify 3 ☐ Widowed 4 ☐ Divorced er than "natura", the Medical E 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magnee. **BOOKKEEPER** BOY SCOUTS OF AMERICA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 SCHU0FF ၉ WILLIAM GREENBAUM CELIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 6606 EDENVALE ROAD - BALTIMORE, MD 21209 MARVIN GREENBAUM / BROTHER 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition ANSHE EMUNAH ATTZ 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD 11/04/2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, the property of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending properties of the second IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions uting to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has certificate After this certific funeral director, 25. Was case referred to medical examiner? 26. Place Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintained and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, Hospital or Attending Physician; the Funeral Director: After Actions of the Funeral Director: After Funeral Director After Funeral Milled in by the funeral Fun within 24

(Check only one) 29b. Signature and title of certi

th (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

21208

Registrar

31. Date filed (Month, Day, Year,

person who on pleted cause of de



State of Maryland / Department of Health and Mental Hygiene Reg. No LU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 28, 2007 2:50 A M Ronald A. Nestor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 M 2 □ F 65 Dec. 11, 1941 Indiana Director 307-42-5996 Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 √ Yes 2 No Director Rockville Maryland | Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or 7 5801 Nicholson Lane #808 20852 United States Pages 1 and 2 should be filed within 72 hours after death Funeral Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner my once. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:1 9 6 3 - 1 9 91 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Power Corporation Personnel Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander J. Nestor Helen Bazin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine A. Billups/Daughter 9249 Paseo De Valencia Street, Ft. Myers, Florida 33908 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. Silver Spring, Maryland 2007 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home Rockville, Inc./ 300West Montgomery Ave. Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licer M01498 23a. Part1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Place of Death (Check only one) 2 No 25. Was case referred to medical Be 2 No Hospital: Other: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 55054 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK AVE. SUITE 409 60 GAITHER BURG 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

NOV 0 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 200735550 State Registrar Amend #5,perFh,g873, 11/6/07 TT Certificate of Death Reg. No. 1. Decement's Name (First, Middle, Last) 2. Date of Death NOVE MBER **Physician** 21:37 1 2007 /Medical 4c. County of Geath Name (If not institt tion, give street and number) 4b. City, Town, or Location of Death Examiner OF BADYORE BATHURE If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 4.1 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F Mary Director 220-64-7315 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ehow. ?7 is marked other than "naturel", or iteme 23s or 28s-f ehov traumatic event, the Modical Examinar must be notified at Mary land 1 Yes 2 No Director Itamore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 You Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Çuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates: Be Completed by 3 Widowed 4 Divorced ae 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busines Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Şeçondary (0-12) College (1-4or 5+) and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be lealth and Mental OSenh 2 Mary 19a. Informant's Name/Relationship (Type, Print) (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If Item 27 is or other tra Baito. 20a. Method of Disposition

1 Burial 2 Cremation 21206 y or Town, State 616 MD20c. Location - City 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit Pages 1
Department of H
Important: If itel
any injury or ott 3 Removal from State Balti More 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Earth Flereral Homes Pa 130 Walloth Avea Balton 21. Signature of Funeral Service Lighnsee P.A. Tatille Willoth Avea 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betweer Onset and Deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PIRATORY BITHESS SYNIDROHE do **Physician** /Medical **Examiner** NRMASILICAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physician end for use as the burial-transit The faw requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? å 1 ☐ Yes 2 ☐ No 3 Pobably 4 Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Ho 24a Was an autopsy certificete 1 🗌 Yes 201 Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2- No 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending death. 1 Tyes 2 No 2 Accident investigation within 24 hours efter deatl To the Furierel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check unity one) 9 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08438 State of Maryland / Department of Health and Mental Hygiene John Irving Ott 3555 I 2007 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 30, 2007 1030 hrs Medical Examiner John Irving Ott 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 509 South Vincent Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Country) WV Hours Months Days March 8. 1950 Director 57 214-54-9307 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. n/a Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21223 509 S. Vincent Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White etc Armed Forces 1 Never Married 2 Married Yes specify: White Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after a neut of Health and Mental Hygiene. If Yes, Give Year 4 X Divorced marked other than "natural", event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Automobile Transmission Mechanic 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charlotte Bradfield Alban Hersel Elmer Ott æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5220 Wasena Avenue Baltimore MD 21225 Charlotte Ott/Mother it: If item 27 is other traumat 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Grave Run Cemetery 1 X Burial 2 Cremation 3 Removal from State 11-02-2007 Alesia, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Ambrose 2719 Hammonds Ferry Rd. Funeral Home Lansdowne MD Lansdowne Signature of Funeral Service License Lansdowne Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Death 'M ical Methadone intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical X UNPENDED physician the burial -AMENDED, 27, 28a-f, perME, g873, 11/9/07 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth use as t past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Division of Vital Records, P.O. icate has been signed by page 2 should be detach Yes 2 No 3 Probably 4 V Unknown þ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 2 No Yes 2 V No certificate 26.Place of Death (Check only one) 25. Was case referred to medical æ Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene FR/Outpatient 3 Inpatient 2 this 1 Yes 2 28d. Describe how injury occurred 28c. Injury at Work's After the 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death Certification: Yes 2 X No 1 Natural Pending death. Fnd 10/30/2007 Fnd 10:10 an To the Funeral Director: completely filled in by the Investigation 2 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be or Town, State)
509 S. Vincent St. Baltimore, MD 3 Suicide determined other-scene Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 31, 2007 O.C.M.E.

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State 31. Date filed (Mortal Pay, Pearls)
Registrar

30. Name and address of person

Zabiullah Ali, M.D.

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

who completed cause of death (Item 23a)

posts

ORIGINAL

		1	For State Registrar	State of M	laryland		rtment of			ntal Hyg	giene Rea. No. 4	2007	35552
(2)			Decedent's Name (First, Middle, La	st)					2	. Date of Dea	ath		3. Time of Death
	Physicia			Walter	Richa	rd Per	-egov			Month	O 5	Year	0441AM
	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City, Town	or Location	of Death		4c. C	ounty of Death	
	-Admin	•	FRANKLIN SQU	ORE HOS	PITAL	Center	Ros.	edale	-		Bo	aLTimo	R. e
	Funeral		5. Social Security Number 6. S	Sex 7. A	ge (In yrs. la	ast birthday)	If Under 1 Yea Months Day	If Under	24 Hrs. 8	. Date of Birt	h v. Year)	9. Birth	place (State or Foreign
- 60	Director		219-16-3642	1 X M 2□F	83	3 Yrs.	Worth Day	I Hours	Nan. 1	MAR 12	, 192	24 Mary	zijand
	D.		Usual Residence of Decedent		10- 01-	Town and a							40d Incide City Limite
	show	_	10a. State 10b. County		10c. City	, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 X No
	e Ma Ba-f s	cto	MD Balti	more				dle Ri	ver				
	or 24	Director	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Cou	ntry?
	ath w 23a ust b	Ta l	3535 Honeysuck					2122				USA	
<u> </u>	r de	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	3. 13. V	Vas Decedent o f Yes, specify C	f Hispanic Ori uban, Mexica	igin? (Specit n, Puerto Ric	fy Yes or No- can, etc.)	- 14	 Race - Ameri Black, White, 	
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72	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		Driver			}	Tra	ansport	ation
1 70 CO	filed Hygi ther		17. Father's Name (First, Middle, Last	")					er's Name (I	First, Middle,			
oeReらり いないといれ Baltimore, Maryland 21215-0036	iges 1 end 2 should be filed within 72 hours after death with the Marylan it of Heelth and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be	Frank	Pei	regoy				Lucy	v.	Ma	ates	
<u> </u>	shou nd M mar	Ε.	19a. Informant's Name/Relationship			19b. Mailir	g Address (Stre	et and Numb	er or Rural I	Route Numbe	er, City or	Town, State, Zi	p Code)
∑ 8	trau		Richard W. Perego	v son		5615	Winthro	ne Ave	nue	Ra1+	imor	e, MD	21 21 4
ය. re, r	f Hee f Hee frem othe		20a. Method of Disposition			ace of Dispo	sition (Name of natory or other p	-	Dat			ation - City or T	
2 6	ages ent o it: If I		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		e I	-	ematory,		11/06	/07	Ra1	timore,	MD
altir	artm ortar Injur	-	21. Signature of Funeral Service Lice	* *		bb 22	. Name and Add	ress of Facili	ity Crem	ation			MD, Inc.
Ba	permit. Pages 1 end 2 s Department of Heelth ar Important: If Item 27 Is any Injury or other trau		1 Xeorga E	Mar The	4_	2	299 Fred	erick	Road				yland 21228
	12.3		23a. Part1. Enter the disease, or con	nplications that cause	ed the death	. Do not ent	er the mode of o	ying, such as	cardiac or i				Approximate Interval Between
	Dhunisian		shock, or heart failure. List only Immediate Cause (Final			+10							Onset and Death
	Physician /Medical		disease or condition resulting in death)		men"								
	Examiner			540 10 (51 4									
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	ıs a consequ	ence of):							
2	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
100.	exec	Exa	resulting in death) Last	Due to (or a	s a consequ	ience of):							
8760	icate be executed physician end s the burial-transit	dical		_ d									
9	tifical ig ph as th	edi											
Вох	death certific attending p	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne pf pregna	ncy	Ectopic pregna	nev			2	3d. Date of deliv	
Φ.	deat e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	at time of de		Other (specify)					Month	Day Year
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Division or Vital Records, P.O.	iclan: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	y P	Part II. Other significant conditions	contributing to death	but not resu	ılting in the u	nderlying cause	given in Part	I.				the cause of death?
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æ	The I	Completed by								perfo	ormed? 2.⊡*Ño	death? 1 ☐ Yes	
<u>ia</u>	lan: rtiffica ttor, p	Be C	25. Was case referred to medical					26. Plac	e of Death (Check only			
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.5	ath. pr: Af	atio	2 ☐ Accident investigation	on				☐Yes 2☐]No				
<u>\S</u>	r Atte er de recte by th	<u>∰</u>	3 Suicide 6 Could not to determined	28e. Place of I	njury - At ho etc. (Specif)	me, farm, str	eet, factory, offi	ce	28	Bf. Location (City or To	Street and wn, State)	Number or Ru	ral Route Number,
	talors aft	Certification:											
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Exa	hysician: To the beaminer: On the basis	of examina	wledge, deat tion and/or ir	h occurred at the vestigation, in n	e time, date a ny opinion, de	and place, ar eath occurre	nd due to the d at the time,	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
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_	10+1		30. Name and address of person who					-		1 =	10. 1	2.2	2 7
			BINH NGUYEN m 31. Date filed (Month, Day, Year)	D 9000	FRANK strar's Signa	Lin S	Quare	DR	BA	LTO	md	212	7/
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			For State Registrar	State of Ma	Tylaliu /		tificate of l		u Men		Reg. No.		35553
	Physicia /Medic	_	1. Decedent's Name (First, Middle, Las LOUISE KEE	NEY	PHE	LPS	5			Date of Dea	oth OS	ZOO Year	3. Time of Death 7 OZOO M
	Examin		4a. Facility Name (If not institution, give HOWARD COUNTY G	street and number)	itospit		4b. City, Town, or CO LUM	BIA, N	ND			County of Dear	
	Funeral Director		220-34-3050	TH OKTE	(In yrs. last b	Yrs.	if Under 1 Year Months Days	If Under 24 H Hours M	lin.	Date of Birt Month, Day 1y 20,	y, Year)	Co	thplace (State or Foreign ountry) yland
	show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Loc	ation						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Ba-f s	Director	MD Howard		Savage	9							
	with the or 2 to be no	Dir	10e. Street and Number 8867 Baltimore St	root			10f. Zip Code 2 0 7 6 3				Ü	zen of What Co	ountry?
	ms 2%	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	/as Decedent of H Yes, specify Cuba	ispanic Origin?	(Specify	Yes or No-	U.S.	14. Race - Ame	
020	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	0		Yes, specify Cuba	Specify:	иепо ніса	Specify: White			
2	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de co <i>mpleted)</i>	16		ent's Usual Occup ind of work done o O NOT use retired		working		16b. Ki	nd of Business	/Industry
7	withir jene. r than the Me	ошо	Elementary/Secondary (0-12)	College (1-4or 5-		omema		,			Own	Home	
2	2 should be filed with and Mental Hygiene. Is marked other thar aumatic event, the In	Be C	17. Father's Name (First, Middle, Last)		•			18. Mother's N	Name (Fi	rst, Middle,	Maiden	Surname)	
y	Ments Ments arked atic e	To E	Felton Edward Kee	eney				Lola F					
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ָ ט	tem 27 i		William B. Phelps 20a. Method of Disposition	s /son			Spencery ition (Name of atory or other place		Date			Le, Mar	yland 20866 Town, State
	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)		ge Ce	metery_	Nov	v 8,	07		age, Ma	
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			23a. Part1. Enter the disease, or comp shock, or hear faiture. List only	plications that caused one cause on each lin							rrest,		Approximate Interval Between Onset and Death
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.C. DOX	sician: The law requires that the death cer certificate has been signed by the attendin rector, page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify) _	/				23d. Date of de Month	Day Year
COLUS, T.	uires that signed by Id be deta		Part II. Other significant conditions of RENAL FAIL	-	it not resulting	in the un	derlying cause giv	en in Part I.				use contribute t	to the cause of death? Probably 4 Donknown
חבכס	he law rec e has beel tge 2 shou	Completed by							_		psy ormed?	prior to death?	
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	Physician: r this certifica ral director, i	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/0	Outpatient	t 3□ DOA Oth	er: 4 🗆 Nursin	ng Home	5 ☐ Resi	dence	6 □Other (Sp	ecify)
	nding Phys ath. r: After this e funeral di		27. Manner of Death 1	28a. Date of Injur (Month, Day	Year) 28b	o. Time of injury	28c. injur Wor M 1 □	yat k? Yes 2∐No	28d	. Describe	how inju	ry occurred	
	al or Atte s after des il Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubuilding, etc	iry - At home, c. (Specify)	farm, stre	eet, factory, office		28f.	Location (City or To	Street ar wn, State	nd Number or F e)	Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C		ysician: To the best on niner: On the basis of and manner sta	examination								
	To th To th	M	29b. Signature and title of certifier	OLLYCIA	الم کم ا		29c. Licens					te signed (Mor	
			► MA ZANO	PHYSIC				2022					, 2007
	\mathcal{Q}_{j}		30. Name and address of person who PEAGA; JACKSON				,	OLUME	51A,	MD	210	944	
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 6 200		ar's Signature	goan.	le)						

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER DES. 2007 12:49FM **Physician** Pierce MAry Sue /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) Examiner Center 8. Date of Birth (Month, Day, Year, January 8, 19 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** West Virginia Days Hours Months 1 □ M 2 F 57 214-54-9865 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show "natural", or items 23a or 28a-f shov sdical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Baltimore Dundalk 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21222 67 Kinship Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Maryland 21215-0036 þ white 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Person 11 years es 1 and 2 should be filed w of Health and Mental Hygier f item 27 is marked other th or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rhoda Nelson Glen Conrad 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 67 Kinship, Dundalk, Maryland 21222 Daughter Jessica Payne Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Memorial 20c. Location - City or Town, State 20a Method of Disposition November permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Middle River, MD. 6, 2007 4 Donation 5 Other (Specify) 22 Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service Licensee 7110 Sollers Point Road, Dundlak, Md. 21222 e. Complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between 23a. Par 1. Enter the disease shock, or heart failure. Onset and Death TWO DAYS CARDIOGENIC SHOCK Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of):
RHEUMATIC HEART DISEASE 30 YEARS Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oil. Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760乞 Physician/Medical as the attending I IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed the should be detailed 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an page 2 s autopsy performe 2 No 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 27. Manner of Death Certification: 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11/05/2007 D36663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 WILLES, STUART R. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MON 0 6 200 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Reg. No. (First, Middle, Last) 2. Date of Death **Physician** Month 8:30 RX 10 2007 /Medical Town, or Location of Death 4c. County of Death **Examiner** mor If Under 1 Year 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) last birthday) **Funeral** 1 M 2 □ F Months Days Min Year) Yrs. **Director** lana permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Me Jical Examina. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral Was Decedent Ever in U.S. Armed Forces?/ 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 □ Divorced 10 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DQ NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) borer Be မှ 19a. Informant's N = e/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or e. Zip Code. Daughter) 616 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Y Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee atelle 23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rosvahe **Physician** Cance nonth disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DENENTIA Sequentially list conditions, any and limit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 ☐ Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' certificate 2 No 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 2 After this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation **₩** Natural 1 Yes 2 🔲 No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year) NOV 0 6

29b. Signature and title of certifier

Shakunmale 32 Registrar's Signature

Snepte MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9650

29d. Date signed (Month, Day, Year)

29c. License number

00053150

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1:30 AM Prestianni Bartolo November 1,2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore, Maryland Ba Himore Cite the Good Samaritan Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**X**M 2□ F 88 Yrs. Director Jan. 30,1919 219-03-0108 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4103 Granite Avenue 21206 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💹 No Specify. White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembler GM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Signorino Prestianni Basilia Bonsignore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Dellwood Dr Nancy Lawrence-Niece Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 11/5/07 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc Baltimore, MD 21206 6415 Belair Rd 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Renal Failure /Medical Due to (or as a consequence of): Examiner End-stage Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diahetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Urinary tract infection 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ► No autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, within 24 hours a To the Funeral I

Registrar

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

Medical

566Thomas Wilson MD PhD 5601 Loch Raven Blvd Baltimore, MD 21239 32. Registrar's Signature

Wilson MD PhD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D40277

29d. Date signed (Month, Day, Year)

November 1,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35557 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 4 2007 **Physician** 4:00 AM /Medical 4b. City, Town, or Location of Death
BALT I MORE 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HARBOR HOSPI Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day Year 07-12-5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**5**€M 2□ F 92 212-05-0533 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or itema 23e or 28e-f ehow empty injury or other traumatic event, it a Medical Examinar must be notified at once. Baltimore 1 Ses 2 No Completed by Funeral Director MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 622 21225 Koad 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: Blac 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life QO NOT use retired) 16b. Kind of Business/Industry Elementary/Seconda contlary (0-12) College (1-4or 5+) ector 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ٥ 1 homas 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 16104 Eastlawn Bowie, MD 20+16 20ь. Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State □ Donation 5 □ Other (Specify) ٥ 21. Signature of Funeral Service ne Funeral Services Balto, MD 21229 reene le 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death OBSTRUCTIV Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner physicien and s the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? sete hes been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ED GAST 1 ☐ Yes 2 No : After this certifical funeral director. 25. Was case referred to medical examiner? 26. Place of Death |Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 😿 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 28c, Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification: 5 Pending investigation t Natural within 24 hours after death. To the Funeral Director: A completely filled in by the fo death. 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DMITE GAGALIX 29c. License number NOVEMBER 4 2007 Darray MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUT h 5 DMITRI GAGARIN, MD BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature Assil

DHMH 17 Rev 1/2001

Registrar

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His Espera

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 196 per file 8873 11-6-07 earth and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Joseph Francis Robinson, Jr. 2007 3:30A Nov. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Towson Baltimore Gilchrist Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 54 March 7 1953 215-58-1792 MD Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show odical Examiner must be notified at 1 ☐ Yes ৡ☐ No Director MD n/a Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5513 Lothian Rd. #1 21212 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Construction Supply 12 n/a Dispatcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Francis Robinson, Sr. Virginia Sterrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jarrettsville Pike, Phoenix, MD 21131 Helen Robinson/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11/8/07 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21. Signature of Funeral So-22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to instruct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of) Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 2 No Hospital or Attending Physician: After this certification funeral director, I 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Balto, Md 2:207 6701

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year

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6 2007

		•	1 - For State Registrar	State of I	Marylan		rtment of H tificate of I			gien Reg. N		3000
		- 1	Decedent's Name (First, Middle, Las	t)					2. Date of De	eath		3. Time of Death
	Physicia		NORMAN	C	R	RUDO	PH		NOU		ay Year 2007	6:27 AM
	/Medic Examin		4a. Facility Name (If not institution, give	street and numb			4b. City, Town, or	Location of Deat			c. County of Death	
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\$ 3.	Funeral		5. Social Security Number 6. Se	ex 7.	Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth	9. Birth	nplace (State or Foreign untry)
	Director		190-20-3456	M 2□F	78	Yrs.	Months Days	nours Min.	Nov. 12	2, 1	928 Penn	sylvania
Т	pr ,		Usual Residence of Decedent		40- 01-	. T						40.11.11.00.11.11
	aryla show	_	10a. State 10b. County			y, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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	or 2	Directo	10e. Street and Number				10f. Zip Code			10g. C	Citizen of What Co	untry?
	s 23a	Funeral	22538 Sweetleaf La				20882				ted State	
	er de Item	nue	11. Marital Status	12. Was Decede	es?	.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	specify Yes of No to Rican, etc.)	0-	 Race - Amer Black, White 	
9	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2 🔀 No	Specify:			Specify: Whi	te
3	hour Itural	edk	15. Decedent's Ed			16a. Dece	dent's Usual Occup	ation		16b.	Kind of Business/l	ndustry
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7	with iene. thar	шо	Elementary/Secondary (0-12)	College (1-4 5+	or 5+)		sician			Fai	mily Prac	ctitioner
2	Hyg Hyg other ent, i	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	_		
<u> </u>	ld be lental ked c	To B	Frederick Rudolph					Signe J	Johnson			
=	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or ftems 23a or 28a-f show important: If them 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at once.	_	19a. Informant's Name/Relationship (7	ype. Print)		19b. Mailir	ng Address (Street	and Number or R	ural Route Numb	per, City	y or Town, State, Z	ip Code)
Ě	nd 2 alth a 27 is r trau		Amy Carver / Daugh	iter		22538	Sweetlea	af Lane.	Gaither	sbu	rg, MD 2	0882
ນົ	f Heg f Heg item othe		20a. Method of Disposition		20b. F		sition (Name of natory or other place	1	Date		Location - City or	
altillo	Page ent o nt: If y or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐				Crematorium		7	Bot	hesda, M	arvland
	nit. F artm ortar Injur		21. Signature of Funeral Service Licen	1	MOIIL	Ligoniery	Name and Addres	ss of Facility	· 1			
Ď	permit Depar Impor any Ir		×. E. (9		M0089	6 30	bert A. H O W. Mont	rumphrey gomerv <i>l</i>	Funeral Ave Ro	. но ckv	me/Rockv ille, MD	ille, Inc. 20850-2805
			23a. Part1. Enter the disease or con- shock, or heart failure. List only	ications that cau	sed the deat							Approximate Interval Between
	Physician		Immediate Cause (Final			2014	10.5	1000	0.4.1			Onset and Death
	/Medical		disease or condition resulting in death)		as a conseq		LINF	ARC//C)/U			7 DAYS
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	cuted Id ransil	Examiner	Cause (Disease or injury that initiated events	C.								
5	an ar rial-tı	Ex	resulting in death) Last	Due to (or	as a conseq	uence of):						
0,00	icate be executed physician and s the burial-transit	dical	•	d								
	rtifice ng ph as th	a)	IF FEMALE:							-		
5	th ce tendii r use	an/h	23b. Was decedent pregnant	23c. If yes, outco	me pf pregna h 2 🗆 Feta		Ectopic pregnancy	,			23d. Date of del	
	ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnar 9□Unknow	nt at time of d	death 5	Other (specify)				Month	Day Year
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ń	gned be de	by I	Part II. Other significant conditions of								A =	the cause of death?
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ב	law r as be 2 sh	Completed	AND RADIA	FION					24a. Was	s an opsy	24b. Were au	utopsy findings available completion of cause of
	The ate h	mo							perf 1□ Yes	formed?	? death? No 1 ☐ Yes	
2	ertifica ctor,	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only			
_	nyslo nis ce dire	To E	1 Yes 2 No	Hospital:	atient 2	ER/Outpatier	nt 3□ DOA Oth	er: 4 \sum Nursing	Home 5□ Res	sidence	6 □Other (Spe	cify)
5	ng PI fter th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o	f 28c. Injur Wor	y at k?	28d. Describe	how in	njury occurred	
2	endli eath. or: A he fu	atic	2 Accident investigation				M 1 🗆	Yes 2 □ No				
<u>~</u>	r Att er de irect	tific	3 Suicide 6 Could not be 4 Homicide determined	Zoe. Flace U	f injury - At ho , etc. (Specif	ome, farm, sti fy)	reet, factory, office		28f. Location City or To	(Street own, St	and Number or Ri ate)	ural Route Number,
2	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Direction: After this certificate has been signed by the attending from the funeral director, page 2 should be detached for use as	Certification:										
	Hosp 4 hou rune ely fij	cal	(Check only 2 Medical Exar	ysiclan: To the b niner: On the bas	est of my kno is of examina	owledge, deat ation and/or ir	h occurred at the till vestigation, in my o	me, date and place prinion, death occ	e, and due to the	e cause e, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)
	the I	Medical	one)	and manne								
	wit do	2	29b. Signature and title of certifier	1			29c. Licens		,_		Date signed (Mont	
	6		Jan fu	amer	MD			06108	3.5	No	V od o	2007
1	,		30. Name and address of person who	·					0 - 0	0 -		1.0 = =
U	<u> </u>		PAUL THAMBI	9707	MED pigrar's Signa		CEWTER	DR.#	300,	KOC	KVILLE,	MD 2085
	Sta	ie	31. Date filed (Month; Day, Year)	32. Heg	mundia Signa	ului C						

State of Maryland / Department of Health and Mental Hygiene 35560 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:20 P M October 31, 2007 Helen Sterling Ritnour /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery Village Health Care Center Montgomery Village | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Hours | Min. | Feb. 5,1912 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months 1 ☐ M 2 🔀 F 213-58-5931 95 Washington, D.C. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be active. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland 1 ☐ Yes 21 No Montgomery Director Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20841 15225 Barnesville Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White 9 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jerome Pierce Matthews ဥ Carrie Belle Sterling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15225 Barnesville Road, Boyds, Maryland 20841 Linda Myers/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place Parklawn Memorial Park November 5, 20a. Method of Disposition 20c. Location - City or Town, State Rockville, Maryland 1 X Burial 2 □ Cremation 3 □ Removal from State 2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert A. Rockville, Inc., 300 West Rockville, Maryland 20850 21. Signature of Funeral Service Lice Pumphrey Funeral Home Montgomery Avenue M01498 23a. Part1. Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to influence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed Severe Atherosclerosis sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performed? 1□ Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 29a. Certifier 1 🔀 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D22978 November 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hiru Khianey, M.D., 19520 Doctor's Drive, Germantown, Maryland 20874 31. Date filed (Month, Day, Year) 32 degistrar's Signature State NOV 0 6 2007 Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] 7 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8.30 AM **Physician** 07 10 STUCKEY 30 BLANCHE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BAHNOV

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Nov. 7, 1 BATHONE HUSDITAL aty Pecours 9. Birthplace (State or Foreign Country)
S. Carolina 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🖳 F Yrs. 237-38-9143 1923 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location Baltimore 10b. County itam 27 is marked other then "netural", or Items 23e or 28a-f show other treumatic event, the Mudical Examinar must be notified at 1√2 Yes 2 No Maryland Directo 10f. Zip Code 21211 10g. Citizen of What Country? 10e. Street and Number 3902 Greenspring Ave 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Black Pages 1 and 2 should be filed within 72 hours after a nent of Health and Mental Hygiene. int: If itam 27 is marked other then "netural", or Itei 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. Baltimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired).

Domestic Engineer Private Homes College (1-4or 5+) Elementary/Secondary (0-12) 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie Pogue Lena 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 3902 Greenspring Ave Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Print) Robert Stuckey/ Husband 21211 20c. Location - City or Town, State 20b. Place of Disposition (Name of 11/5/07 20a. Method of Disposition permit. Pages 1 Department of H Important: If its any Injury or ot once. Mt. Zion Cemetery Lansdowne, 1 Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Eyneral Service Licenses alrin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a Examiner ANASAYCA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Malunton Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Cher (specify) been signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b autopsy performe 2/500 1 ☐ Yes 2 ☐ No or Attanding Physician: 26. Place of Death Check only one Be 25. Was case referred to medical Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 ဂ္ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 2 🗌 No investigation 2 ☐ Accident within 24 hours after death To tha Funarel Director: , completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To tha Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

3

State Registrar 30. Name and address of person who compile

31. Date filed (Month, Day,

JUSFAH

MD.

\$2. Registrar's Signature

1940 W. BATHMON ST

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7State Registrar Amend #5,perFH,g873, 11/26/07 TT Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Month Year **Physician** ayson 0625 AM November 3,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sinai Hospital of Baltimore Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. 21, 2007 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 M M 2 □ F 182-84-8869 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. City, Town or Location 10a, State 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA orrev 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Mamied 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced "natural", ed other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Be ၉ 19b. Mailing Address (Street and Number or Mount Wolf, AH other lorre 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physic iell NECrotizina 24 hours Enterocoliti /Medical Due to (or as a consequence): Examiner Ktreme prematu Sequentially list conditions, if a.ry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signad by the a 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 TYes 2 TNo within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MEdical 0040362 NOVEMBER 3, 2007 Director 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. BEIVEDERE AVE O'BriEn M.D. BaltimorE, Md Thomas HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar NOV 0 6 2007

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State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician Harry Lee Simmons /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Country) Virginia Months 1 X M 2 □ F Director 225-44-0202 July Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? þ 23a 1041 Harrison Drive 20707 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or itei 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Engineer 11 Apartment Complex 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rocky D. Simmons, Sr. Geneva Gertrude Pickett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau once. Mary Ann Simmons 1041 Harrison Drive, Laurel, Maryland 20707 /spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ivy Hill Cemetery Nov 6, 07 Laurel, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, 21. Signature of Funeral Service I cen P.A. M00773 Maryland 20707-4389 313 Talbott Ave. Laurel, Approximate Interval Between Onset and Death 23a. Part1. Enter the gisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head allufe. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** OV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical the ! IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 ☐ Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 3 ☐ Probably 4 ☐ Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2□ No 1 ☐ Yes 1□ Yes 2 No rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 phpatient 1 ☐ Yes 2 ☐ No ို 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certific 29c. License number 29d, Date signed (Month, Dav. Year) 24289416 VO University Parkway 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

31. Date filed (Month, Day, Year)

NOV 0 6

2007

Division or Vital Records, P.O. Box 68760,

marke

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital committee within 24 hours after death.

To the Funeral Director: After the Funeral Director of the Funeral Dir

Sta

d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy τ (specify)		23d. Date of de Month	livery Day Year
	ributing to death but not resulting in the underlying to the underlying to the underlying to the underlying to the underlying the underlying to the underlying the underlying to the underlying the underlying to	ng cause given in Part I.			o the cause of death? robably 4 7Unknown
			24a. Was an autopsy performed? 1□ Yes 2 ☑ N	death?	utopsy findings available completion of cause of
25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ R/Outpatient 3		th (Check only one) ome 5 🗆 Residence	6 □Other (Spe	ecify)
27. Manner of De th 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Street and City or Town, Sta	and Number or R ate)	ural Route Number,
	cian: To the best of my knowledge, death occu er: On the basis of examination and/or investig and manner stated.				
29b. Signature and title of certifier	. ~~	29c. License number		Date signed (Mon	
> Amil & Mazo	ppleted cause of death (Item 23a) (Type, Print)	D506850	10	1/53/5	1007-
				V.MD	
31. Date filed (Month, Day, Year)	32. Registrar's Signature	20 + 3	1		
NOV 0 6 200	7 Maria M. Spark				
	e estable				
	ORIGIN	AL			

Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 2, **Physician** Laurence Taylor Scott 2007 7:00 A^{M} /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 11609 Toulone Drive Montgomery Potomac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 7, 9. Birthplace (State or Foreign 5. Social Securi 7. Age (In yrs. last birthday, **Funeral** 1 X M 2 □ F Months Days Hours Min. Washington, D.C. 578-34-7904 79 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ns 23a or 28a-f shov must be notifled at 1 ☐ Yes 2 No Director Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 11609 Toulone Drive United States filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Korea "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify þ Specify: 3 Widowed 4 Divorced White Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Attorney Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ermina McCarthy George Washington Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) Dolores Scott/Wife 11609 Toulone Drive, Potomac, Maryland 20854 Date 5, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gate of Heaven Cemetery Nov. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State etery 2007 Silver Spring, Maryland
22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/ Chase, Inc.
7557 Wisconsin Ave., Bethesda, MD 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00198 23a. Part1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Months Immediate Cause (Final Physician Metastatic Esophageal Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) P.0. 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Congestive Heart Failure has performe 1 Yes 2 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 ☐ Yes 2 💢 No P 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1X Natural 5 Pending To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3□ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059244 November 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Giselle Mery, M.D. 11510 Old Georgetown Road, Rockville, Maryland Giselle Mery, M.D.

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

NOV 0 6 2007

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 01, 2007 Paula Mae Sponaugle 4:25 P.M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford County Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Havre de Grace, MD 8. Date of Birth (Month, Day, Year)
May 12, 1964 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 F 215-86-5746 43 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Harford County Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 1716 Melwood Court 21040 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) n/a Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul Wilson Sponaugle Dorothy Mae Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dorothy M.C. Lopez (Daughter) 802 Windstream Way Apt. A Edgewood, MD. 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Yourial 2 ☐ Cremation 3 ☐ Removal from State Highview Mem.Gardens Nov.07,2007 Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Immediate Cause (Final CANC WITH METASTASIS ING 4 WEEKS disease or condition resulting in death) Due to (or as a consequence of): LIWEEKS METASTASI IVER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autonsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

/Medical Examiner or Vital Records, Division or Attending To the Hospital or Attend within 24 hours at er death To the Funeral Director:

Examiner Physician/Medical þ Completed Be 2 Certification:

Medical

State

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

other than "natur

Item 27

permit, Pages 1
Dapartment of H
Important: If ite
any injury or ot

Physician

Director

Funeral

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Completed

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

DESH SHARMA, MD 602 S. ATWOOD RD# 106 BELAIR MD 210 129 32. Registrar's Signature

MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D31856

11/01/2007

				State of Maryla				-	•	·•	
			For State Registrar		Ce	rtificate of L	Death	+	g. No 200		
	Physici		1. Decedent's Name (First, Middle, Last) JOHN MEYERS SCHA	\ \FFER				2. Date of Death Month Novembe	່ r ື2,2007ື	ar 7:50A M	
3.68	/Medio		4a. Facility Name (If not institution, give s Stella Maris			4b. City, Town, or	Location of Death	L	4c. County of D		
Ī	Funeral Director		5. Social Security Number 6. Sec. 205–26–2045	7. Age (In y	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, February	9. 3,1930 Pe	Birthplace (State or Foreign Country) ennsylvania	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation	<u> </u>			10d. Inside City Limits	
	Maryl a-f sho ified at	ctor	Maryland Baltimor	re C	ockeysvi	ille				1 ⊡Yes 🏋 🕅 No	
	with the a or 28 be not	Director	10e. Street and Number 1035 Saxon Hill Dr	rive		10f. Zip Code 21030		10	g. Citizen of What USA	Country?	
	death	Funeral		12. Was Decedent Ever in	n U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-	14. Race - A	merican Indian, /hite, etc.	
980	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	by	1 □ Never Married 2 □ Married 3 □ Widowed 4 🛣 Divorced	XXYes 2⊡No W If Yes, Give Year or Dates:	WII	1 □ Yes XX No	Specify:	riodii, oto.)	Specify:		
15-0	n 72 h n "natu ledical	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of worl l)	king 1	l6b. Kind of Busine	ess/Industry	
212	ed within rgiene. er than " the Mee	Somp	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Tea	acher/Orga			Baltimore	e County	
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar to f Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be (17. Father's Name (First, Middle, Last) Quinton Alvin Scha	affer			Irene	e (First, Middle, M Meyers	aiden Surname)		
Mar	and 2 sho ealth and n 27 Is ma er traum		19a. Informant's Name/Relationship (Ty Ruth Ann Carroll	rpe. Print) DTR		ng Address (Street a Saxon Hi				_{le, Zip Code)} yland 21030	
ore,	of Hea		20a. Method of Disposition 1 Burial XX Cremation 3 F	Removal from State	b. Place of Dispo cemetery, cre	osition (Name of matory or other place	(e)	- 1	20c. Location - City		
Itim	t. Pa tmen tant: njury		Donation 5 Other (Specify) 2 Signature of Funeral Sania License	1		nt Cremato	• !			e, Maryland	
Ba	2/Signature of Funeral Social Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Social Licensee 6500 York Road Baltimore, Mary										
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final	ications that caused the d ne cause on each line.	leath. Do not en	ter the mode of dyin	ig, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	Due to (or as a con							
	Examiner	-	Sequentially list conditions,	b Due to (or as a con	sequence of):						
	cuted nd ransit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	D							
760,	te be executed ysician and e burial-transit	cal Ex	resulting in death) Last	Due to (or as a con	sequence of):						
89	rtificate ng phys	Medic	IF FEMALE:	0							
.O. Box	the death certificate by the attending physicached for use as the backed for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ f 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	<u>'</u>		23d. Date of Month	delivery Day Year	
Δ	that ed b	by Phy	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	ınderlying cause giv	en in Part I.	23e. Did tob	acco use contribu	e to the cause of death?	
ords	w requires that been signed by should be deta							1 □ Ye	s 2 No 3 No	Probably 4 X Unknown	
or Vital Records,	ne law has b je 2 st	Completed						24a. Was ar autops perforn	y prior ned? deat		
ital		Be Co	25. Was case referred to medical examiner?				26. Place of Dea	1 Tes 2 th (Check only one	2 ½ No	Yes 2□No	
or/	Phys this al dir	မ	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient : 28a. Date of Injury	2 ER/Outpatie		4 □ Nursing H		nce 6 Other (Specify) HOSPICE	
sion	Attending r death. ector: After by the fune	ation	1 Natural 5 □ Pending investigation	(Month, Day Yea	r) Injury		k̂? Yes 2 □ No				
Division	l or Attu after de Directu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Sp	At home, farm, st pecify)	reet, factory, office		28f. Location (Str City or Town	reet and Number o , State)	r Rural Route Number,	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C		rsician: To the best of my iner: On the basis of exar and manner stated.							
	To the within To the compl	Me	29b. Signature and title of certifier)		29c. Licens			9d. Date signed (N	fonth, Day, Year)	
	or				(II 00) (T	Dried)	4372		11/2	107	
1	0		DR. TARIO MAHMOOI	2300 DIII.A	NEY VALI	TEV RD	TIMONIUM.	MD 2109	3		
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's S	ignature	will .		· ····································			
	Regist	rali	NOV 0 6 200	Called Control	1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** G. Robert Smith Jr. atober 300 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital N/A Baltimore City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **X**□M 2□F 218-28-6997 78 Director October 15,1929 Morganitown, W. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Sparrows Point 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3112 Whiteway Road 21219 USA Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23 ury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White δ 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Bethlehem Steel Steel Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert G. Smith Loreen McGee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan McMillen daughter 2927 Craigston Lane, Abingdon, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o November 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Baltimore, Maryland 5,2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due th (or as a consequence or): MES /Medical **Examiner** 3D LEGG CABO Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dute Respiratory Dates Syndrane
Due to (or as a consequence of): be executed sician and burial-trans P.O. Box 68760, physician Physician/Medical the as use IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death ned by the a 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 1□ Yes 2 DN6 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient P 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred ul or Attending Fafter death. Division 5 Pending investigation Injury 1 Yes 2 No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ont) one)

State Registrar 29b

agnature and title of certifier

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DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

Mctiveen, DO

29c. License number

Union Memorial

MRGH-JUPBEUSTA

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Ma	ryland / [Departme Certifica	nt of Health te of Deat	and Mo		ene 2 () j. No.	107	35569
	Physici /Medic		1. Decedent's Name (First, Middle, La Alvin	<i>D</i> .		Sa	nders	Sr. ,	2. Date of Death Month Vovembe	Day /	Year 2.007	3. Time of Death 0410 AM
	Examin	er	4a. Facility Name (If not institution, given TOHNS HOPKINS (5. Social Security Number 6. S	3MYVIEW M	EDICAL CE	NIER	ty, Town, or Location BALT I M Ber 1 Year If Und	n of Death		4c. County		olace (State or Foreign
	Funeral Director			₩ 2□F		Yrs. Month		s Min.	Month, Day,		Maryla	ntry)_
	Maryland -f ehow	tor	10a. State 10b. County Maryland Baltimor	re	10c. City, Town	or Location					1	0d. Inside City Limits 1 ☐ Yes 2 📉 No
	with the	i Direc	10e. Street and Number 937 Dalton Avenue			10f. 2	Zip Code 2122	24	10	g. Citizen of USA	What Coun	ntry?
036	2 should be tiled within 72 hours after death with the Maryland and Menial Hygiene. is marked other than "naturel", or items 23a or 28a-f show is marked other than "naturel", or items 23a or 28a-f show eumatic event, the Madical Examiner must be notilled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 MYes 2 N If Yes, Give Year or Dates:		If Yes, s	cedent of Hispanic becify Cuban, Mexic 2 X No Speci	Origin? (Specan, Puerto F	cify Yes or No- Rican, etc.)	14. Rac Bla	ce - Americ ck, White, y: Whi	etc.
21215-0036	d within 72 ho glene. rr than "natur ine Medical	Completed	15. Decedent's E. (Specify only highest grant Elementary/Secondary (0-12) 8 years	ducation de completed) College (1-4or 5-	+)	Decedent's Us (Give kind of single) life. DO NOT		ost of workin	ng 1	Sb. Kind of B	usiness/Ind	dustry
		To Be C	17. Father's Name (First, Middle, Last, Drury B. Sanders S					ther's Name Adams	(First, Middle, M	aiden Sumai	π 0)	
, Mary	and 2 sho salth and 1 n 27 ie me er treums		19a. Informant's Name/Relationship (Jean A. Sunell	Type, Print) Daughter	43	34 Clyd	ess (Street and Num ebank Dri					
Baltimore,	permit. Pages 1 and 2 should by Depenment of Health and Menia Important: if item 27 is marked eny injury or other treumatic evone.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)		20b. Place of cemeter	Disposition (A ry, crematory of n Forest	lame of Ir other place) . VA Cemeter	_ Nove	mher	oc. Location		
Balt	Depertit. Depertit Import eny inj		21. Signature of Funeral Service Licer	Conn	elly	7110	Ily Funer Sollers F	oint I	Road, Du	ndalk,	P.A. MD. 2	21222
) 10.	Physician /Medical		23a. Part1. Enter the disease, of common shock, or heart failure. List only temmediate Cause (Final disease or condition resulting in death)	Pulne	the death. 66 res.	ede		as cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death
	Examiner •	er	Sequentially list conditions, if any, leading to immediate	b. Pher	LULD ILL	4						2 days
87605	ficate be executed physicien end is the burial-transit	dical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence	of);						
Box 6	death certi e attanding od for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopio 5 □ Other				1	ate of delive	ery Day Year
	0 00	ρ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the underlying	g cause given in Pa	rti.				ne cause of death?
T	The ite h	Completed				-			24a. Was an autopsy perform	ed	Were auto prior to condeath?	psy findings available impletion of cause of
Z Z	ysician: lis certifica director, p	Be	25. Was case referred to medical examiner?	Hospital:					(Check only one			
ō	Phys r this ral dii): To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injur	v 28b. 1	tpatient 3	28c. Injury at Work?		ne 5 Resider			(y)
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director;	Certification:	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	9 290 Place of Inju	ry - At home, fa	njury M irm, street, fact	1 ☐ Yes 2		28f. Location (Str. City or Town,		ber or Rura	al Route Number,
	To the Hospital or Attenwithin 24 hours eftar deati To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Pr (Check only 2 Medical Example)	ysicien: To the best on the basis of and manner sta	examination an	e, death occurred/or investigati	ed at the time, date on, in my opinion, o	and place, a death occurre	and due to the ca ed at the time, da	use(s) and m	anner as s and due to	tated. o the cause(s)
)	To the within To the Comp	Me	29b. Signature and title of certifier Frank A	Kwaa r.	Nedical	Doctor	29c. License number	er O	29 X /	d. Date sign	ed (Month,	Day, Year)
	5		30. Name and address of person who Frank Akwaa M-L 31. Date filed (Month, Day, Year)	completed cause of de	eath (Item 23a)	(Type, Print) Avenue	Balt	imore	mo	2/2	.24	,
	Sta	te	31. Date filed (Month, Day, Year)	007 32 Registra	r's Signature	forth	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2007 November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under (In yrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age last birthday **Funeral** Months Days 1□M 2**F**F 129-07-1386 Director Vew YOCK Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 No **Funeral Director** 10e. Street and Number More 10g. Citizen of What Country? 10f. Zip Code Mosher 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 S If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☑ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Praetical Nuise Medi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ 19a. Informant's Name/Relationship (Type. Print) (Doughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2906 W Mosher šhe arla 21216 MO 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 □Removal from State Baltimory 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses North MD 21216 complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Two weeks Physician neumon /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the use as attending IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f Division or Vital Records, P.O. 9 Unknown 9 Unknown cate has been signed I, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 **X** No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 npatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061765 vember 12007

State Registrar then ever

31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

3350 WILLIAMS AND #307 BACTIMENTS IND 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Udin 03

S

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 20b per fib 9873 11-13-07 vt
State of Marviand / Bepartment of Health and Mental Hygiene

Reg. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** m 2120 AM November 2007 Helen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Care Center

s conial Sacurity Number 8. Sex 7. Age (In yrs. last birthday) Baltimere City Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Director 213 26 8896 MAR.19,1930 MD. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other treumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No MD. N/A BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 21206 4749 SHAMROCK AVE. USA Items 23s Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Importent: If Itam 27 Is marked other than "natural, or Item any injury or other treumatic event, the Medical Experiment once. 1 ☐ Yes 2 ☐X\0 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK þ 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry HARBOR VIEW Elementary/Secondary (0-12) College (1-4or 5+) NURSING HOME 12TH NURSING ASSISTANT 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle | ast) Be LAWRENCE H. PATTERSON GENEVA SMITH 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MINYUN PATTERSON (daughter) 4749 SHAMROCK AVE. BALTO, MD. 21206 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Oak lawn. Cemeters 1 Removal from State 4 Denation 5 Other (Specify) NOV.10,2007 BALTIMORE, MD. ature of Funeral Service Licensee B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementia 10 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and s the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ Ho 0 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nonknown Stroke Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2/2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No 2 Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death 28b. Time of Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Diractor: 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide within 24 hours a To the Funerel I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0051185 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hopkins Bayuraw Circle, Baltimore, Mary land Colleen Christmas, 32 Hegistrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Nov. 2007 Sharon Doris Spitzler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore** 3452 Dunran Rd Dundalk 8. Date of Birth (Month, Day, Year)
July 28,1952 . Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🔀 MD 215-64-4500 55 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 ☐ No Director Baltimore Dunda1k MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 3452 Dunran Rd Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 → Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, the Longe. Own Home 10 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Goedeke Paul Peranio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3452 Dunran Rd Dundalk, MD 21222 George Spitzler Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 K Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 11/5/2007 Glen Burnie MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Charles S. Zeiler and Sons, Inc. Baltimore, MD 21224 6224 Eastern Ave complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, shock, or heart failure Immediate Cause (Find disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit that the death certificate be executed Exami Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown After this certificate has been si funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy perform 1∐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home SX Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Matural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

6 Trimbl JM.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene James Torrence, Jr. 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 2, 2007 0157 hrs Medical Examiner James Torrence, Jr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltmore Sinai Hospital N/A 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Mar • 24 , 1938 1 9 Foceign Mar • 24 , 19 8 Scountry) Md 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Hours Days Min. Months Director 216-34-8824 XXM 2 69 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1XXYes 2 No 28a-f show s 23a or 28a-f show s notified at once. Baltimore N/Aimore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21215 2414 Liberty Height Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes 2 X No or. Specify: Black Yes 2 X No specify: 4 X Divorced If Yes, Give Year 3 Widowed ρ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than ' Marriott Hotel Cook 3rd grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Myrtle C. Harris James Torrence, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 229 1303 Woodington Rd Apt. Andre Torrence/Son Baltimore, 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, Greenmount Cemetery other t Burial 2 X Cremation 3 Removal from State Baltimore, Department o Important: injury or oth Donation 5 Other Specify. 22. Name and Address of Facility Chatman-Harris Funeral Home ature of Funeral Servi Reisterstown Rd Baltimore, Md 21215 Approximate Interval the diffease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. Ist only one cause on each line. /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease *aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X AMENDED, perFh, C873, 11/6/07 TT tending physician a UNPENDED 68760, 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Live birth Fetal death Month Day Pregnant at time of death 5 Other (Specify) Box 1 Yes 2 No 9 Unknown g Unknown Ö contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 V Unknown σ. has been signe 2 should be do Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? page certificate Yes 2 1 🗸 Yes No 25. Was case referred to medica 26.Place of Death (Check only one) director, Be Other: examiner? Hospital: 1 DOA Other Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 After this ۵ 1 🗸 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Division 1 V Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and litle of certific November 2, 2007 O.C.M.E. OCME 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

Registrar

Pamela E. Southall, MD

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31. Date filed (Month, Day,

32. Registrar's Signature

Charles -

Physician /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ms 23a or 3

?7 is marked other than "natural", or items: traumatic event, the Medical Examiner mu

nd Mental Hygiene. marked other than

is marked of

Department of Health ar Important: If item 27 is any Injury or other trau

Director

Funeral

Completed by

Be (

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0036

Physician/Medical Examiner burial-tran use for signed by Be Completed by cate has been sig page 2 should b Certification: To 24 hours after death filled in by

Division or Vital Records, P.O. Box 68760,

Cause (Disease or injury that initiated events resulting in death) Last	c. Chronic Obstructive Due to (or as a consequence of):	e Pulmonary Dise	ease	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown		opicpregnancy ner (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	s contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Congestive Hear	t Failure		1 ☐ Yes 2	2 No 3 Probably 4 ☑ Unknown
Hypertension			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐XER/Outpatient 3	B DOA Other: 4 Nursing Hon	ne 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 ★Natural 5 Pending 2 Accident investigat		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
27. Manner of Death 1		factory, office	28f. Location (Street at City or Town, Stat	nd Number or Rural Route Number, le)
29a. Certifier 1 Certifying	Physician: To the best of my knowledge, death oc aminer: On the basis of examination and/or invest and manner stated.			
29b. Signature and title of certifier	^	29c. License number	29d. Da	ate signed (Month, Day, Year)

November 1, 2007

State Registrar

within 2.

DHMH 17 Rev 1/2001

9901 Medical Center Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Martin McGreivy

MOV 0 6

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 Month **Physician** 5:15 P. M November May Frances Roder Thornton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gaithersburg Montgomery Herman Wilson Health Care Center | Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State of Months | Days | Hours | Min. | Sept. | 23, 1910 | Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 97 188-05-1112 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 TYes 2 No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 United States 9508 Michaels Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny linjury or other treumatic event 908. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Rose Stanley Edwin George Roder 19a. Informant's Name/Relationship (Type, Print) (daughter) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9508 Michaels Ct., Bethesda, Maryland 20817 Sara May Thornton Oetting 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 5 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2007 Bethesda, Maryland Montgomery Crematorium, Inc. 21. Signature of Funeral Service icense Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Vascular Dementic y-ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the deeth certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, hed by the attending physician detached for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart 1 Yes 2 No 3 Probably 4 Unknown been : 24b. Were autopsy findings available prior to completion of cause of death? Hypertension has autopsy performed' this certificate 2 \ No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ Mô 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 HNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 041794 Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell Avenue Gaitfersburg, MP Misaille Callahan Lyon 911 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 2335 October 30 2007 <u>Enrique Armando Vidal</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAINT AGNES n/a HEALTHCATE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last hirthday) 6. Sex 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Hours Min. 1**X**M 2□F Director 4/27/14 93 Cuba 262-78-9424 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Director Catonsville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1219 Redcliffe Road 21228 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 2 3 Widowed 4 Divorced Cuban Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinery Chemical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Lonronzo Vidal Asunsian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1219 Redcliffe Rd. Catonsville, Maryland 21228 Mrs. Orlanda L. Vidal / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 iCremation 3 ☐ Removal from State 4 ☐ Donation 5 Other (Spartombment Loudon Park Cemetery 11/6/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 uges 23a. Part1. En er the disease, shock, heart failure. Us eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death omplications that caused the only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Embolism Pulmon ary 10minuks /Medical Due to (or as a conse wence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be exec Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonary effusion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ûnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No athle rosclerosis 24a. Was an autopsy performed?, Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural ∠ Accident 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD DEA 669916795 Ochber 31, 2007 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) 3 Baltimore Maryland 21212 900 SWILL COTON Avenue Checkler Meghan 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 0 6 2007 Registrar

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Vital Records,

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Division

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d	Physici		Decedent's Name (First, Middle, McKinley Lee)	,	Sr.					Date of Death		3. Time of Death
ed.	/Medic		4a. Facility Name (If not institution, 205 Spesutia		mber)		4b. City, Town, or Aberde			Ovembo	4c. County of Dea	th
	Funeral Director			.Sex XXM 2□F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. 8. Min. A	Date of Birth (Month, Day, pril	9. Bir 20, 1937	thplace (State or Foreign ountry) Marvland
	P		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation					10d. Inside City Limits
	e Maryla ka-f shov tifled at	ctor	MD Har:	ford	100.01		berdeen					1 ☐ Yes 2 No
	th with th 23a or 28 ist be no	al Director	10e. Street end Number 205 Spesutia 1	Road			10f. Zip Code 21	001		10	g. Citizen of What Co USA	ountry?
980	be filed within 72 hours after death with the Maryland ital Hygiene. so other than "natural", or ltems 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	Armed Fo	2 X No ve No		Was Decedent of H f Yes, specify Cuba I □ Yes ※XXNo	lispanic Oric an, Mexican Specify:	gin? (Specif i, Puerto Rid	y Yes or No- can, etc.)	14. Race - Ame Black, Whi Specify: B	te, etc.
21215-0036	in 72 ho 1 "natur 1edi al 1	Completed	15. Decedent's (Specify only highest	grade completed)		16a. Deced (Give life. i	lent's Usual Occup kind of work done o OO NOT use retired	ation during most	t of working	1	6b. Kind of Business	/Industry
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/land	2 should be filed v n and Mental Hygie i s marked other t raumatic event, th	To Be	17. Father's Name (First, Middle, La Matthew White						r's Name <i>(F</i> Cy Av		laiden Surname)	
Man	D = C =	2	19a. Informant's Name/Relationship Joan E. White	Wife							City or Town, State, Maryla	
Baltimore, Maryland	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other		20a. Method of Disposition 1X Nourial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		State Sh	Place of Dispo cemetery, crer arpe	sition (Name of natory or other place St. U.M.	e)11/9	0/07 ^{Pate} Cem	. 2	Chase, Ma	·
Balt	permit. Depart Import any inj once.		21. Signature of Funeral Service Li	larres		4	. Name and Addres	ss of Facility air R	Chati	man-Ha altimo	arris Fu	neral Home yland21206
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8760,	cate be executed physician and the burial-transit	dical Ex	rossing in death, East	d	or as a conseq	uence of):						
Box 68	nding use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐Live I	tcome pf pregni pirth 2 DFeta nant at time of c	al death 3	Ectopic pregnancy Other <i>(specify)</i>	1			23d. Date of de	livery Day Year
P.O.	at the d by the tached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkn		leatii 5L	Tottler (specify)					
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/ital	ctor, pa	BeC	25. Was case referred to medical examiner?					26. Place	of Death (C	1□ Yes 2 Check only one	iZNo 1 □ Yes	3 2 No
Or /	Physician: this certific ral director,	2	1 Yes 2 No	Hospital: 1 28a. Date	Inpatient 2	ER/Outpatien		4 L Nu			nce 6 Other (Spe	ecify)
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Division	al or Attending s after death. Il Director: After ed in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 26e. Place	of inju ry - At h	ome, farm, str	eet, factory, office		28f.	Location (Street) City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	caminer: On the b	e best of my kno asis of examina ner stated.	wledge, deatl ation and/or in	occurred at the tirvestigation, in my o	ne, date an opinion, dea	d place, and th occurred	due to the ca at the time, da	use(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	100	10		29c. License	e number		29	d. Date signed (Mon	th, Day, Year)
_	7		30. Name and address of person w	no completed caus	e of death (iter	n 23a) (Type,	Print)	458	3	1	Jovembe	r 2, 2007
- 6	Sta	to	31. Date filed (Month, Day, Year)	102 a	tegistrar's Signa	MP ature	8	LAN	1 ->)	veet	why and	raten
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle Last) 02-2004 **Physician** an /Medical County of Opath 4a. Ficility Name (If not institution, give street and number) wn, or Location of Death **Examiner** saltimore atonsville are Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) Number 6 Sex **Funeral** Months 1□M 2**V**F 85 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show Pages 1 and 2 should be filled within 72 hours after death with the Maryla nent of Health and Mental Hygiene.

The should be seen that the should be seen that the state of the should be seen that the should be seen to other traumatic event, it is the slots the seen that the should be seen that the s 1 Yes 2 □ No Completed by Funeral Director nmore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Blac 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during n life, QO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (Firs 17. Famer's Name (First, Middle, Last) To Be own, State, Zip Code) 19a. Informant's Name/Relationship (Tvp. lstown, MD 21133 20b. Place of Disposition (Name of cemetery, cremator) or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Funeral Services Rendallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLITI DIFFICILE Physician CLOSTRIDIUM disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner . The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Year Month Day page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes CARDIO VAS CHLAR 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day 27. Manner of Death 5 Pending 1 🗌 Yes 2 🗌 No investigation 2 Accident 24 hours after death a Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 / Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely

State Registrar

D0059107

29c. License number

29d. Date signed (Month, Day, Year)

m m. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

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DRIVE REISTERSTOWN 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 0 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:35 1KING 2007 /Medical 4a. Facility Name (If not institution, give street and number) ity, Town, or Location of Death 4c. County of Death Examiner Landelli fond 1541 trmore Mois The west If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1X M 2□ F Director 102-24-8315 81 2/19/1926 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at XXYes 2 No MD BALTIMORE TOWSON Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 1 COOPERATIVE DR. #318 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1XX lever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify à Specify. 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION LABORER 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F JOE WILKINS, SR. MINNIE SILVER ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health a 1 COOPERATIVE DR. # 318 BALTIMORE, MD 21212 MARIE M. JETER/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages 1 Department of I Important: If ite any Injury or ot 1XBurial 2 ☐Cremation 3 ☐Removal from State 11-07-2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) MT. CALVARY CEM 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Palty. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physiclan 1 REMIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): the burial-Box 68760. attending physician pe Physician/Medical use as t IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P. 0. the detached 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed page certificate 1∐ Yes 2 X No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ٩ 1 npatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident filled in by the within 24 hours after deat To the Funeral Director 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai t 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ent) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig

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31. Date filed (Month, Day, Year)

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30. Name and ddress of pers in who completed cause of death (Item 23a) (Type, Print)



Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Olive Doris Wilbraham $\underline{\mathbf{A}}^{\mathsf{M}}$ 29. 2007 7:15 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner <u>Carriage Hill</u> Bethesda Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, June 14, 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Months Hours Davs Min. 1 ☐ M 2 🔀 F 95 578-74-3456 Director France Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Chevy Chase Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20815 8101 Connecticut Avenue United States Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23s Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: <u>ک</u> White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugenie Brunier Albert Edouard ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7501 Wisconsin Avenue, Bethesda, Maryland 20814 Marny McCain/Trust Officer 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. Date 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: if ite any Injury or of once. Nov. 1, 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Crematorium, Inc. 2007 Bethesda, Maryland

22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Chase, Inc.
7557 Wisconsin Ave., Bethesda, MD 20814-3501

he death. Do not enter the mode of dving such as cardian averaging. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALLURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy Month 5 Other (specify) this certificate has been signed by the arid director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🔽 🗸 To 1 Yes 2 ₩00 or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be 1 Yes 2 No Other: Aursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) 1 Aatural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20057124 10 (29/07 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Truong Bao, M.D.

1 - State Registra
1. Decedent's

2. Date of Death

Physician
/Medical
Examiner

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Gilchrist Center Towson 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Months 1 □ M 2 X F 83 Director 234-36-5510 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or the traumante event than "natural" or the 10c. City. Town or Location 10a. State 10b. County Director Maryland Harford County Joppa 10e. Street and Number 10f. Zip Code 21085 1109 Hollingsworth Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify ģ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Ó3 Home Maker n/a 17. Father's Name (First, Middle, Last) Be William Pleasant Dearfield Ada May Rose 19a. Informant's Name/Relationship (Type. Print) Mary Rose (Daughter) 1109 Hollingsworth Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Evans Funeral Chapel Nov.03,2007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 2325 York Road rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INFETTON Physician URINARY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Ro 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed ORONAPY ARTEMY DISEASE 24a. Was an autopsy performed 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🐪 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide Medical 29a. Certifier D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12

32. Registrar's Signature

November 02,2007 3:38 A. M Anna Margarette West 4c. County of Death Baltimore County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | North Country | North Birthplace (State or Foreign Country) 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21085 Joppa, Maryland 20c. Location - City or Town, State Forest Hill, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A. 21093 Timonium, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSACE 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 6565 NCHARLES ST. SUITE 209 BALTIMORE. MO 21204

State Registrar DANIEUE DOBEMUAN, MO

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State Registrar Certificate		a moman		2007	35582
i	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Month	D.	ay Year	3. Time of Death
	/Medic		DEBORAH A. WEATHERBY		Octok		•	
99	Examin	er		wn, or Location of D	eath	4	c. County of Deat	n
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24 I		f Birth Day, Yea, 27/19	9. Birt 930 MAR	hplace (State or Foreign untry) YLAND
	pu ,		Usual Residence of Decedent					40-d Impide City Limits
	Marylar a-f shov	ctor	MD 10a. State 10b. County 10c. City, Town or Location BALTIMOR	E				10d. Inside City Limits 1 X Yes 2 No
	3a or 28 st be not	al Director	10e. Street and Number 10f. Zip Co	ode 211			Citizen of What Co JSA	untry?
ING 21213-UU36 be filed within 72 hours after death with the Maryland tital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	after deat or Items 2 miner mu	Funeral	1 Never Married 2 Married 1 Yes 2 No	nt of Hispanic Origin' Cuban, Mexican, P	? (Specify Yes o uerto Rican, etc	r No-	14. Race - Ame Black, White	e, etc.
5-0036	hours ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			10h		ITE
-612	hin 72 l e. In "nat Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	done during most of retired)	working	166.	Kind of Business/	industry
7	ed witi ygiene ier tha t, the	Com	Elementary/Secondary (0-12) College (1-4or 5+) TEACHER				DUCATIO	N
and	be bd od	Be	17. Father's Name (First, Middle, Last) NEWTON WEATHERBY		M. SHE	,	,	
Maryland	2 should be and Menta Is marked raumatic ev	은	19a. Informant's Name/Relationship (<i>Type. Print</i>) 19b. Mailing Address (<i>S</i>					Zip Code)
	D = 1. =		KARL AUMANN(P.O.A.) 538 WYNGA		JTHERV:	LLE,	MD. 21	093.
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name cemetery, crematory or other GREEN MOUNT)		Date RY11/01		BALTO	
Ball	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee 22. Name and A HENRY 16924	Address of Facility W • JENK] YORK RD	INS & S	SONS	CO. 2111	1
	*		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.)• <u>ZIII</u>	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition and Spiration blumon					Onset and Death Immediate
	/Medical Examiner		resulting in death) Due! (or as a consequence !): C. I. Obstruction					5-6 days
	7 #	ner	Sequentially list conditions, if any, leading to immediate					1. 1.
 2p	death certificate be executed e attending physician and d for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	esions				lingstanding
68/60 ,	ate be nysicia he bur	Medical	d					
_	ag d	Med	IF FEMALE:					
.C. E	w requires that the death cer been signed by the attendir should be detached for use	Physician//	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic preg				23d. Date of del Month	ivery Day Year
ω̈́ L	law requires that the as been signed by the 2 should be detache	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.	23e.	Did tobacco	use contribute to	the cause of death?
ecords,	require			···	_	1 🗌 Yes	2 No 3 Pr	obably 4 Onknown
Ľ	The farate has	Completed			-	Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of 2 No
νпа	Physician: r this certific ral director,	Be (25. Was case referred to medical examiner?	26. Place of Other:	Death (Check o	nly one)		
0	Phys r this rral dir	. To	1 Pinpatient 2 EH/Outpatient 3 DOA	. Injury at Work?			6 ☐Other (Spe jury occurred	cify)
lon	nding ath. r: Afte e fune	ation	1 Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation M	Work? 1 ☐ Yes 2 ☐ No			,,	
DIVISION	To the Hospital or Attending Phys Within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directorial.	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, o building, etc. (Specify)	office	28f. Locati City o	on (Street a r Town, Sta	and Number or Reate)	ural Route Number,
	ne Hospit 1 24 hour ne Funera	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.					
	To the within To the comp	Me	29b. Signature and title of certifier 29c. L	icense number	946	29d. D	Date signed (Mont	h, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nichael A-Sirota, M.D. Which	Memoir		1 /	Rallin	noire
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	INTERNOR	-01 1103	rial	Saitir	
	Registr	-	NOV 0 6 2007 Legen & Spark					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2055 NOVEMBER ON 2007 Alice L. Young /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL AGNES n/a If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Days Hours Min 1 □ M 2 🛪 F West Virginia 3/11/28 235-38-7475 79 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐Yes 2 No Director MD Catonsville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 IISA 923 Sedgley Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Naomi Belcher Nolan Goodrich Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. William E. Young / Husband 923 Sedgley Road Catonsville, Maryland 21228 20b. Place of Disposition (Name of Barrelling remains Wellands 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 11/5/07 Baltimore, Maryland @ Loudon Park 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Lice 3620 Wilkens Ave. Baltimore, Maryland 21229 Approximate Interval Between Onset and Death blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final SEPTIC day SHOCK disease or condition resulting in death) Due to (or as a consequence of) BOWEL 13 CHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 25. Wa 1[

Physician /Medical Examiner the death certificate be executed

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

s 1 and 2 should be filed with Health and Mental Hygier tem 27 is marked other th

Pages 1 and 2 ment of Health au nt: if item 27 is 1

Department o Important: If any Injury or

traumatic event.

burial-tran physician s the buria Physician/Medical as attending properties page 2 s this certificate has Medical Certification: To After 1 neral Director: / / filled in by the f

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Vital Records,

Division or

The law requires

Hospital or Attending Physician:

within 24 hours after To the Funeral Dire

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ıminer?]Yes 2 ∑ N	lo	Hospital: 1 Sinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify							
nner of Death Natural Accident	5 ☐ Pending investigation	the second secon	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred		
] Suicide] Homicide	6 ☐ Could not be determined		At home, farm, stree oecify)	t, facto	ry, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,		

(Check only one) 29b. Signature and title of certifier

27. Ma

1) 2[

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

0 (Qee

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A WTON GUEOR GUIEV

CATON AVE DALTIMORE MO 21229

State Registrar

31. Date filed (Month, Day, Year) NOV 0 6 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2007 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 1732 M Charles 2007 arborough October /Medical 4c. County of Death 4b. City, Town, or Location of Death acility Name (If not in Sitution, give street and number) Examiner Salisbure Vedica. Nicomico (enter Kegiona eninsula If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Mary Land 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F Hours Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla oppertment of Health and Mental Hyglene in "ratural", or Items 23a or 28a-f show Important: It flem 27 is marked other than "ratural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1V Yes 2 □ No Maryland Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Armed Forces 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT µse retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) condary (0-12) College (1-4or 5+) Baltimore 18. Mother's Name (First, Middle, Maidert-Burname) Saltimore, Maryland 17 Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SIStes) 19a. Informant's Name/Relationship Aype. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) borough Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 S Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 □ Donatio 22 Name and Addr. ss of Facility 21. Signat of Funeral Service Licensee Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart dailure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIC Immediate Cause (Final disease or condition resulting in death) Physician DAY /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and Due to (or as a consequence of): signed by the attending physician a P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, IMMUNODEFILIENCY VIRUS POSITIVE 1 Yes 2 No 3 Probably 4 Donknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 3□ D0A 2 🗍 JV 1 Inpatient 2 FR/Outpatient P 27. Manne eath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending (Month, Day Year) 1 2 atural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1062416 00,70BER 31,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SVERLAND 1415 SONT DIVISION SUITE & SMISBURY MO 2180) 6anerrez 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

hur Ziegler	,	S 1- For State	tate of Maryl	and / Depa Ce	artment of	f Health and f <i>Death</i>	Menta	al Hygiene	Reg. No.	200	7	3558
Physici		Registrar 1. Decedent's Name (First, Mid	dle,Last)					2. Date of D Month	Dav	Year	 Time of 2245 	
edical Exam	α	Arthur R.						October	31, 20		2245	1115
		4a. Facility Name (if not institut	ion, give street and r	iumber)		4b. City, Town, or L	ocation of	Death	40	N/A		
		Union Memorial Hos	pital			Baltimore	If Under	24Hrs 8 Date of	Birth(MM	IDDAWW G Birth	hplace (St	ate or
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days		Min.		Foreigi	msyl	vania
Director		181-38-6518	1 X M 2 F	52	Yr	S		Mar.	/,	1955 Per	HISY,	vanta
*		Usual Residence of Decedent 10a, State 10b, Count		10c. Cit	tv. Town or Loca	tion						de City Limits
, w					Baltim	oro					1XXY	es 2 No
land -f sho	호	Maryland N,	/A		Darcin	10f. Zip Code			10g. Ci	tizen of What Cour	ntry?	
Mary r 28a	Directo	836 W. 37th S	troot			21	1211			USA		
1215-0036 d be filed within 72 hours after death with the Maryland fental Hygiene. narked other than "natural", or items 23a or 28a-f show any vent, the Maryland Allone must be notified at ource.	E	11. Marital Status		ecedent Ever in	U.S. 13. W	as Decedent of His	panic Orig	in? (Specify Yes or	No-	14. Race - Ameri	can Indiar	n, Black,
ath wi tems st be	Funeral	1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married Armed Forces?										
er de:	교	3 Widowed 4 XX	Divorced If Yes, Give Y	ear 2XX NO	1	Yes 2 X No				Specify: Whit		
urs aft tural'	l b	15 Decedent's Education (S			16a. Decede	ent's Usual Occupat most of working life	tion (Give I	kind of work done use retired)		Kind of Business/ oftware I		opment
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036 ithin ne. r thau	Completed	12 4 Software Development 18. Mother's Name (First, Middle, Maiden Surname)										
5-0036 Ted within 77 Hygiene. If other than	ا ق											
21215 uld be fill Mental F marked	B	Richard Arth	ur Ziegle	<u>r</u>	19h Maili	ing Address (Stree	Pe et and Num	arl Bath	Number,	City or Town, State	e, Zip Cod	le)
Should be fill and Mental I	٦	19a. Informant's Name/Relation	Fiance		836	W. 37th	Stre	et, Balti	more	, Maryla	nd 21	211
Z pult		20a. Method of Disposition			b. Place of Disp	osition (Name of ce	metery,	Date	200	c. Location - City o	r Town, St	tate
Baltimore, permit. Pages I ar Department of He Important: If ite		1 Burial 2 Crema	ition 3 Remova	al from State	crematory or	other place) rematory		11/9/200)7 C	atonsvil	le, N	Maryland
Baltimore permit. Pages 1: Department of H. Important: If it	5	4 Denation 5 Other 21. Significant Services 21	Specify:				s of Facilit					-11117
Ball		21. Signature of Funeral Service 1. Signature of Funeral Service 1. Signature 1. Si	3 CXP	111	ا ا	rgee-Hen	ss-Se	eitz Funer Baltimo	ral H	lome, Inc Maryland	. 212	211
		23a, Part /, Enter the disease	e, or complications the	at caused the de	eath. Do not ente	r the mode of dying	, such as	cardiac or respirator	y arrest, s	shock, of heart	Appro	een Onset and
Physicia 'Medica		laliture. List only one ca	I Iranosat					lar disease	_			Death
amine	r	Immediate Cause (Final dise or condition resulting in deat		as a consequence		0010 001-01						
		Sequentially list conditions,	b									
	ā	if any, leading to immediate		as a consequent	ce of):							
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Box 68760, e death errificate b the attending physic	for use	1 Yes 2 No 9	Malarana 7	Inknown	5	Other (Specify)						
the d	ched G	Part II. Other significant co	onditions contributi	ng to death but i	not resulting in t	he underlying cause	e given in f	Part I. 23e.		cco use contribute		
cords, P.O. law requires that that the bear signed by	e deta							1	Yes		_	4 V Unknown
ds, equire	pluc 3							24a	. Was an autopsy	24b. Were prior t	autopsy fi to complet	indings available tion of cause of
COL law ri has b	2 sho	<u> </u>							performe Yes 2		i? Yes	2 No
Division of Vital Records, tall or Attending Physician: The law requirers after death.	ector, page	5	adical			26.Pla	ace of Deat	th (Check only one)				
tal ician: certi	ector	25. Was case referred to me examiner?	Hospital:	Inpatient	2 V ER/Outpa		Other ₄	Nursing Home	5 Re	esidence 6 O	ther:	
of Ving Physical After this	lal di	1 Yes 2 No	28a.	Date of Injury	28b. Time		njury at Wo	ork? 28d. De	scribe hov	w injury occurred		
ding h. After	- fune	1 X Natural 5	Pending	Month, Day,Year)		1	Yes 2					
ivisior or Attenc after death Director:	by the	1 X Natural 5 2 Accident 3 Suicide 6 4 Homicide	Investigation 28e.	Place of Injury -	- At home, farm,	street, factory, offic	e building,	etc. 28f. Loc	ation (Str	eet and Number or	Rural Ro	ute Number, City
O'V'S affer 1 Dire	ui pa	3 Suicide 6	Could not be	ecify)				or	own, sta	ie)		
ospita	ly fill				owiedge, death o	occurred at the time	, date and	place, and due to t	ne cause(s) and manner as	stated.	- (-)
Division Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	completely filled in by the funeral	(Check only cone) 2 Medica	I Examiner: On the b	asis of examinat	tion and/or inves	stigation, in my opin	ion, death	occurred at the tim	e, date at	ia piace, and asset		se(s)
To	COI	(Check only one) 2 Medica 29b. Signature and title of c	and mai	nner stated.			ense numb		- 1	29d. Date signed	(Month, D	ay, Year)
		11/1 /	1	M		О.	C.M.E.			November 1,	2007	
		30. Name and address of p	person who complete	d cause of death	ı (Item 23a)				-010-			
17		Melissa Brassell,		t Medical Ex	caminer 1	11 Penn Street	t, Baltim	ore, MD 21201				
U	Sta	Ot Date Charles Date		32. Registrar's S	Signature	AP						
Re	gisti		0 6 2007	May some	JK A	agale A						
DHMH 17 Pe	v 1/20	01	.4		ORIG	INAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Chester Adams, Sr. 5:33 A October 14 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year)
Dec. 5, 1915 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Davs 422-09-2104 91 Georgia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Director MD Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20715 USA 2407 Kegwood Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bakery Baker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elma Hudson Unknown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia L. Adams / spouse 2407 Kegwood Lane Bowie, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 10/20/2007 Alexandria, VA. 4 Donation 5 Other (Specify) 21, Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 20715 6512 NW Crain Hwy. Bowie, MD. Ou 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shock **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Tract Infectio Examiner rococcus Sequentially list conditions, it any, learing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Physician/Medical ast IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Farluse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? 1 TYes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA funeral 27. Mann Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital the

Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Armoel Medicolcenter Annapolis MD HOWARD YOUNG MD

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only

29b. Signature and title of corti

32. Registrar's Signature

1 🖵 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D00058297

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** OCTOBER 11, FRIC ALSTON 2007 6:57A /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 579-04-7085 40 12-11-1966 DETROIT. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show MD PRINCE GEORGE CAPITAL HEIGHTS 1X Yes 2 No notified Director 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 4718 QUADRANT ST 20743 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. is 1 and 2 should be filed within 72 hours after in thealth and Mental Hygiene. Item 27 Is marked other than "natural", or item 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: BLACK þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical Elementary/Secondary (0-12) 12th College (1-4or 5+) DISABLED NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HOWARD PAGE LENA ALSTON 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 COREEN SPRIGGS/AUNT 4718 QUADRANT ST CAPITAL HEIGHTS, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State HARMONY CEMETERY 10-20-2007 LANDOVER, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility JE JENKINS FUNERAL HOME 21. Signature of Funeral Service License 7474 LANDOVER RD LANDOVER, MD 20785 K. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, o shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final **Physician** Corongr disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and Due to (or as a consequence of) burial-1 P.O. Box 68760. signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chron ate has page 2 s autopsy performed certificate bid 2 No 2 No MOR 1 Yes Physician: ector, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Certification: or Attending 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital

State

Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

R 31. Date filed (Month, Day, Year)
OCT 2 3 2007 m D

mD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

DUTHERN AUR SE

29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Mooth Day, Year) 2 3 2007

Genevieve Wroblewski, MD



Mobilevish

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



LLUN

D64615

6001 Muncaster Mill Road, Rockville, MD 20855

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Items

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Department of Health and Mental Hygie Important: If Item 27 Is marked other any Injury or other traumatic event, it

the Medical E

Examiner

Director

Funeral

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Completed

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examiner burial-transi as # atten for u signed by the a this certificate has ral director, page 2 After

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

or Attending Physician:

the

Physician/Medical Completed by Be Medical Certification: To s after dec... ral Director: After

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes at No 1\□ Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

(Check only

29b. Signature and title of certifier MD D58853

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 10/30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHOTANI 251

East Antietam Street, Hagerstown, MD 21740

State Registrar

10

31. Date filed (Month, Day, Year) 06



within 24 hours a

To the Funeral I

completely filled Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35590 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 18, 2007 **Physician** 7:30 a Beverly Ann Brockman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 3410 41st Avenue Colmar Manor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Feb. 5, 19 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🔀 F 213-40-8752 1942 New Orleans, LA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show "natural", or items 23a or 28a-f shov dical Examiner must be notified at Colmar Manor 1 X Yes 2 □ No Prince George's Maryland | Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20722 U.S.A. 3410 41st Avenue Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ White 3 ☐ Widowed 4 ☑ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) Stone Industrial, Inc. Machinist permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important; If Item 27 is marked other i any Injury or other traumatic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Granville B. Coffman Pauline Foltz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Randall B. Coffman-Brother 43425 Leener Lane, Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 10/23/2007 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 21. Sign vire of Funeral Service License 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 MOILIGH / Un helle 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CHNOCKIL **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Unorthing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ How in the prior to completion of cause of death? 24a. Was an page 2 autopsy certificate Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 Pending investigation Natural 1 ☐ Yes Hospital or Attendl 24 hours after death. Funeral Director: A death. Accident completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the within 2 To the I State Registrar

31. Date filed (Month, Day, Year) OCT 2 3 2007

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHURCH AT LORGE TO 20707

State of Maryland / Department of Health and Mental Hygien 2 17 35591 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Brookbank LaMont Atwood October 19, 2007 0137 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1**X** M 2□ F 578-12-0480 Yrs. Oct. 4,1919 Director 88 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14100 Ryceville Road 20659 USA deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1**X** Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Accountant Construction . Pages 1 end 2 should be filed v tment of Heelth and Mental Hygia tant: If Item 27 is marked other t jury or other trsumatic sysnt, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brookbank Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Susan B. Brookbank/Spouse 14100 Ryceville Rd., Mechanicsville, MD 20659 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Brinsfield-Echols 10/20/2007 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 - M00817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of): Examine The law requires that the death certificate be executed physicien and s the burial-transit Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown should should 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? cate hes t certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: tor: After this certific the funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 R/Outpatient Medical Certification; To 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Deatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Injury efter death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗆 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) of certifie 5302

Registrar

DHMH 17 Rev 1/2001

State

30. Name and addre

31. Date filed (Month, Day, Year)

Dr. Manoj Panwala

on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Charlotte Hall, MD 20622

State of Maryland / Department of Health and Mental Hygier 👂 🎧 🦳 🧻 35592 1 - For Stete Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MCKENCIE shne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NANTICOK 20465 NANTICOKE DR. Wicemico 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 577-36-9729 Days Hours Min. 1□M 2|7 F Months Yrs. WASHINGTON DC Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10a. State 10b. County 1 ☐ Yes 2 XNo Director MD NANTICOKE WICOMICO 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code rthan "natural", or items 23e or the Modical Exoniner must be 21840 USA NANTICOKE DR 20465 Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after all Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ADVERTISING COMMERCIAL ARTIST 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) mit. Pages 1 and 2 should be fili partment of Health and Mental Hy portant: If item 27 is marked oth injury or other traumatic event Be ALEXANDER DOMALD METERZIE GEFTRUDEYIFGINIA STRANAHAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SCAR MULLICHE DIS MANTICHE LUD BIRAD MARGARET HOWISON DAUGHIER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 2 Surial 2 Cremation 3 Removal from State important: if any injury o BALA CYNUND PA 16-30-2007 * 4 ☐ Donation 5 ☐ Other (Specify) W LAURZE HILL CEM 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23a. Part 1. Edde the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. permit. Departn Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ARTERY DISEASE CORDNARY /Medical Due to (or as a consequence of): **Examiner** Atheroscheroric Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a nonsequence of Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 □ Yes 2 No 3 Probably 4 □Unknown TENOS IS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy perform 1 ☐ Yes fo the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ¥Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification; 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 107 D36576 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10015 560 RIVERSIDE DO SAMSBURY MD RONALD IRAUTIZ 31. Date filed (Month, Day, Year) 32 egistrar's Signature State OCT 23 2007 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes 35593 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ď℃£29, 2007 4:55am **Physician** Crider Delpha Marie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland Devlin Manor Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth NOV 14, Yel 916 Birthplace (State or Foreign County) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 ☐ XF 214-07-4264 90 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Bant: If item 27 Is marked other than "natural", or Itams 23s or 28s-f ahow ury or other treumatic avant, the Medical Examinations that be notified at 10c. City, Town or Location Cumberland Allegany 10d. Inside City Limits 10a, State MD 1 X Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 17409 Buckley Road S.E. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) custodian School Board 18. Mother's Name (First, Middle, Maiden Sumame)
Libby Virginia Clower Buckley 17. Father's Name (First, Middle, Last) Be Lemuel Caud Buckley 2 ^{19a} Informant's Name/Relationship *(Type, Print)* daughter 1991 794109 Aggless (Streetend Norther or Rural Route Number City or Town, State 76-Cog 1502 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 1 Department of It Important: If ite Davis Wemonai Cemetery 11/2/2007 MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nam Soarpelli F Emeral Home, PA any in 108 Virginia Avenue: Cumberland, MD 21502 23a. Pol 1. Into the disease, or convilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Due to (or as a consequengle of): resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Ďav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 AMatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after death To the Funerel Director: in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Oct. 30, 2607 DO017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ND 21502 922 N2T1 177 LaUzie 31. Date filed (Month, 32 Registrar's Signature State LES EAST Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra(Amend#20b. PenFHPGC10-31-07cm Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILLIAM JAMES CROWE, JR OCT 18 2007 3:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral ™** M 2□ F Months Days Hours Director 448-20-0035 Jan.2. 1925 Kentucky Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 Yes Director Prince Georges Mitchellyille 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 0 items 23a 10450 Lottsford Road, #5012 Funeral 29721 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Tyes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of the and Mental Hygiene.

27 is marked other than "
r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) other than 12 5+ Naval Admiral US Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William James Crowe, Sr. Eula Russell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trat once. Mrs. Bambi C. Coval- Daughter 3407 Cameron Mills Rd., Alexandria, Va. 22305 20b. Place of Disposition (Name of Cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Navel Academy Cem. 10/31/07 Annapolis, Md. 21. Signatural Service Licensee 22. Name and Address of Facility Everly Wheatley Funeral Home 1500 W. Braddock Rd., Alexandria, Va., 22302 M01453 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of yone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jesus of Injury) that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tunetal director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 🔀 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 2007 0101240449 (VA)

State Registrar 31. Date filed (Month, Day Year)

JAMES R. HOLLIS LT MC USN 32. Registrar's Signature 1.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATIONAL NAVAL MEDICAL CENTER

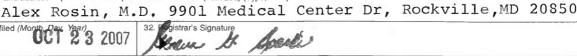
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State Registrar

31. Date filed (Month, D 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and the of certifier



Physian

29c. License number

D0065325

29d. Date signed (Month, Day, Year)

10/17/07

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			Registrar 1. Decedent's Name					tinoato or .		2. Date of D	eath		3. Time of Death
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	ms 23	Funeral Director	11. Marital Status	eywerr La	12. Was Deceden	t Ever in U.S	S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin	(Specify Yes or N		4. Race - Ame	erican Indian,
٥	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Mr. Acal Examiner must be notified at		1 Never Marr	ied 2X Married	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give			t Yes, specity Cuba 1 □ Yes 2 ☒ No	Specify:	uerto Hican, etc.)		Black, White	te, etc.
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ភ្ន	"nati	Completed		15. Decedent's E- cify only highest gra	ade completed)		16a. Deced (Give life. L	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of t)	working	16b. Kin	d of Business	/Industry
7	withii iene. than the M	dwo	Elementary/Seco	ndary (0-12)	College (1-4o	r 5+)	Homen		,		Ow	n home	
0	offiled offiled offiler rent, 1	BeC	17. Father's Name	(First, Middle, Last	· · · · · · · · · · · · · · · · · · ·		110111011		18. Mother's	Name (First, Middi			
yland	uld be Menta Menta rrked rrked	To B	Harris	on Bloome	er				Marge	ery Dixon			
Mar)	2 sho and t Is ma		19a. Informant's Na			. 1	1	ng Address (Street					Zip Code)
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saltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural; or Items 23a or 28a-f show any Injury or other traumatic event, the Markeal Examiner must be notified at once.			☐Cremation 3 ☐	Removal from Stat	e c	emetery, crer	natory or other plac	i		_		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 1:20a M October 25 2007 Helen Valarie CRIDER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Retirement Center Williamsport Washington Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) ear if Unde 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 💢 F 91 Director Maryland 220-80-4029 July 24 1916 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 X Yes 2 □ No Director Maryland | Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a 14. Race - American Indian, 1508 Howell Road Funeral 21740 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 - 120 Homemaker Her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther George Coss <u>Marguerite Vera Trovinger</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara S. Harrell - Daughter 17855 Carter Lane, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose <u>Hill</u> Cemetery 10/27/07 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home E. Wilson Blvd. Hagerstown, Maryland 21740 Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the porde of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mont 1 Yes 2 No 9 Unknown Month 5 Other (specify) 9 Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas autopsy performed 2□ No 1□ Yes 2 No 1 ☐ Yes the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 2 Accident (Month, Day Year, Injury 5 Pending To the Hosping. within 24 hours after death.
To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide i 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur (a 30. Name and address

VH-3

State Registrar 31. Date filed (Month, Day, Year)

OCT 2 6 2007

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 21 John Willard Couchman 2007 7:34PM /Medical October 0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood of Williamsport Williamsport Washington County 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Davs Hours Director 220-10-3109 92 7 1915 West Virginia March Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notifled at Maryland Washington XXYes 2 □ No Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a 12806 Oak Hill Avenue 21740 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than. Elementary/Secondary (0-12) College (1-4or 5+) 12 Plant Supervisor Food Company marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other trainmatter. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Couchman Jennie Small Couchman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Great-nephew 707 Hamilton Ave. Chambersburg Pennsylvania Craig M. Bonebrake -20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 □ Cremation 3 □ Removal from State Rose Hill Cemetery 10-25-2007 Hagerstown Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service License Eastern Blvd. N. Hagersotwn Maryland 21742 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-trans that the death certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical as 1 the attending IF FEMALE: use If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown signed by Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient မ 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No death investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year)

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:20 P M 2007 October 21 CHILMAN DOROTHY GRACE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sandy Spring Montgomery Brooke Grove Rehab and Nursing If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 2X F Months 87 228-66-2158 England 1920 Sept. 6 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show must be notified at 1 ☐ Yes 2 No Montgomery Village Director Montgomery Md. Pages 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-ury or other traumatic event, the Medical Examiner must be notif 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20886 20309 Oyster Bay Terrace United Kingdom 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian Grant Battershell Herbert 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Julia Kauflin / Daughter 20309 Oyster Bay Terrace, Montgomery Village, Md. 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 10/22/07 Metropolitan Crem. Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Gastonforma lamarta **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of) physician s the buria Division or Vital Records, P.O. Box 68760, Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the ard be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 2 NO Yes : After this certification, I 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the Hospital or Attending Physician: The law requires that the death certificate be executed I Director: After to d in by the funera within 24 hours af

To the Funeral D

completely filled in

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rster her I. ys, my egistrar's Signaty

814, Prince Philip Do. Olney, us

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

039793

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

determined

4 Homicide

29b. Signature and title of certifier

29a. Certifier

Medical

State Registrar

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State of Maryland / Department of Health and Mental Hygien 2	007	

		For State Registrar	State o	f Maryland		rtment of				jienę og. No.	007	356	01
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Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. las		If Under 1 Yes	ar If Under	24 Hrs. 8.	Date of Birth (Month, Day	Year)	9. Birth	place (State or intry)	-
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To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical one)	Examiner: On the bi	asis of examination	n and/or inv	estigation, in m	y opinion, dea	ath occurred a	at the time, d	ause(s) ar	ace, and due	to the cause(s)	
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7		30. Name and address of person	who completed caus	se of death (Item 2	(Type		0.01	, _		CLOD	C1	2007	
0,		Gita C. Bakshi,				,	Bethe	esda N	Marvla	nd '	20814		
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Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2 0 7

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/Media		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death		4c. Co	unty of Death	
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E E	ner	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S.	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14.	Race - Amer Black, White	
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othe		20a. Method of Disposition		20b. Place	of Disposition (Name of ery, crematory or other pl		Date		ion - City or T	Town, State
		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci		/ Crema	ntory of Delmarya	1	2/2007	Delm	ar, DE	
important any injury once.		21. Signature of Funerel Service Lice	nses	100						
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- 6 4		Talinable	alson		Lewis N. 1618 West	Watson Fu Rd., Sal	isbury,	MD_21	801	
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ician		shock, or heart failure. List only Immediate Cause (Final disease or condition	applications that cause	line.	Lewis N. 1618 West	Watson Fur Rd., Sal ring, such as cardiac	isbury, or respiratory a	MD 21 rrest,		Approximate Interval Betwe Onset and Dea
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2 0 0 7 35603

			1 - Stete Registrar	(Certificate of L	Death	Reg	g. No.	
			1. Decedent's Neme (First, Middle, Last)				2. Date of Death Month	Dey Year	3. Time of Death
	Physici /Medio		Ernest Lee Cole	onna				17, 2007	1735 "
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or	Location of Death		4c. County of Dee	th
н			9946 Oak Terrace I	Orive	Mardela	Springs		Wicomic	0
	Funeral		5. Social Security Number 6. Sex		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Bir	thplace (State or Foreign
	Director		228-42-6963	75 Yr	S.		Aug. 8,	1932 Vir	ginia
	pue *		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town o	or Location				10d. Inside City Limits
	sho	'n							1 ☐ Yes 2√2 No
	Pe N	Director	MD Wicomic	Marde.	la Springs		10	g. Citizen of What Co	
	with	ក់		\			10	U.S.A.	ountry?
	eath ne 23	Funeral	9946 Oak Terrace I		21837 13. Was Decedent of His	enanic Origin? /Sne	acifu Vas or No-	14. Race - Ame	arican Indian
	Her d	5	1 ☐ Never Married 2XX Married	Armed Forces? 1 🛱 Yes 2 □ No 1951-	If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, Whit	
336	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1954	1 ☐ Yes 2 No	Specify:		Specify:	white
21215-0036	filed within 72 hours after death with the Maryland Hygiene. kther then "naturel", or Iteme 23a or 28a-f show ont, Ite Medical Examiner must be notified at	Completed	15. Decedent's Educ	cation 16a. D	ecedent's Usual Occupa	ition	10	6b, Kind of Business	/Industry
215	bio 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done di ife. DO NOT use retired)	uring most of worki	ng		
2	d wit	PO.	12		lpping clerk	K.		manufactu	ring
b	e file at Hy roth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
/lai	uld b Menti arked	10	Arthur Colonna			Florenc	e Beasle	у	
Maryland	and and is mu		19a. Informant's Name/Relationship (Typ		Mailing Address (Street a	nd Number or Rura	I Route Number, (City or Town, State,	Zip Code)
Σ.	and salth		Charlotte Ann Co.		0. Box 302	Fruitlar	nd, MD 2	1826	
ore	of He		20a. Method of Disposition 1	comotoni	isposition (Name of crematory or other place	Oct. 2	22, 2007	oc. Location - City or	Town, Stete
Ĕ	Pag ment ent: i		*4 □ Donation 5 □ Other (Specify)		ill Memory			Hebron, Ma	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Iteme 23a or 28a-f show eny injury or other treumatic svent, Ite Medical Examination to other treumatic svent, Ite Medical Examination to other treumatic svent, Ite Medical Examinations to other treumatic svent, Ite Medical Examinations to other treumatic svent, Ite Medical Examinations to other treumatic svent, Item Medical Examinations to other treumatic states and the major of the Medical Examination to other treumatic states and the Medical Examination to other treumatics.		21. Signature of Funeral Service License	9	22. Name and Address Short Fune:	s of Facility			
<u> </u>	20223		Cony Short		13 E. Grove	e St. De			
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do not e cause on each line.	t enter the mode of dying	g, such as cardiac o	or respiratory arres	it,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metas	tatic skin	concur			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of)		50,1100			7,400,5
14	Examiner		Sequentially list conditions						
	pe ii	Iner	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying	Due to (or as a consequence of)					
	eath certificate be executed attending physician and for use as the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)					
68760,	be ex cian burial			Due to (or as a consequence or)					
87	cate physi the	Medical	d						
×	ding Se as		IF FEMALE:	3c. If yes, outcome of pregnancy				and Date of de	P
Bo	atten for u	slan	in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	Day Year
Ö.	the d	yslc	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	3 d Other (specify)				
Ω.	The law requires that the death ce ite has been signed by the attendi bage 2 should be detached for use	by Physician	Part II. Other significant conditions con	tributing to death but not resulting in the	ne underlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
sp.	uires n signi	q p					1 ☐ Yes	2 □ No 3 □ P	robably 4 🗆 Unknown
00	w requir been si should l	lete					24a. Was an	24h Were a	utopsy findings available
Re	The larate has	Completed					autopsy performe	prior to death?	completion of cause of
ā	(0		25. Was case referred to medical			26. Place of Death			2 □ No
5	Physician: r this certificaral director, I	To Be	examiner?	ospital: 1 Inpatient 2 ER/Outp	Othe	777-1-1-1-1	,	ce 6 Other (Spe	(market)
ō	g Phys er this eral dt	Ë	27. Manner of Death	28a. Date of Injury 28b. Tim	ne of 28c. injury	at :	28d. Describe how		ony
<u>o</u>	Attending I r death. ector: After by the funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Inju		r res 2 □ No			
Division of Vital Records,	or Attendate death	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office		28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
	s afte	Certification:	4 - Homicide	building, etc. (Specify)			City of Town,	Siale)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, o er: On the basis of examination and/o	death occurred at the time	e, date and place, a	and due to the cau	se(s) and manner a	s stated.
	in 24 in 24 in 6 F	edical	one)	and manner stated.	investigation, in my opi	mion, death occurr	ed at the time, dat	e and place, and du	of to the cause(s)
	To To T	Σ	29b. Signature and title of certifier		29c. License		290	d. Date signed (Moni	h, Day, Year)
1	114		Inda natu		005	7359	00	lober 19 Th	2007
5	11/1		30. Name and address of person who cor						
	1VH		DR-USHA NATESA		ision st, s	ALISBURY	MON	604	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature	Sainett !				

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Robert S. Dragan October 23, 2007 17:36 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 38 Rock Creek Drive E1kton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F Director 176-16-8646 Oct. 10, 1921 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Ceci1 E1kton Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 38 Rock Creek Drive 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No
If Yes, Give
Year or Dates 1942-45 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Worker Bridge 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen Dragan Naomi Zieber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Rock Creek Drive, Elkton, Maryland Reeble Sue Dragan / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Mayerdale Crematory 24, 2007 Newark, Delaware 4 Donation 5 Dother (Specify) 21. Sign of Fineral Service Lite Asee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed signed by the attending physician and deetached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 21 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No 2 this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1/Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral E Eartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To the I within 2

State Registrar

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and

32. Registrar's Signature

mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

<u>G.</u>

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Пау Year **Physician** DONAWAY 2007 10 20 /Medical Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** THE LAKE WICOMICO COASTAL HOSPICE AT ALISBURY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F 99 DELAWARE AUG. Director 217-03-6012 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director WHALEYVILLE WORCESTER MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21872 'natural", or items 23a 8107 DONAWAY ROAD USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 TYES 2 No 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: WHITE 3 Nidowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) MANAGER RETAIL 8 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Health and Mental JOSHUA В. MITCHELL ANNIE Μ. WILSON ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau 12245 BLUEBERRY ROAD, WHALEYVILLE, MD 21872 IRA W. HUDSON/SON 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10/24/07 WHALEYVILLE, MD DALE CEMETERY 21. Sign vire Fineral/Service Lig 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** DEMBN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YPERTE Sequentially list conditions, if any leading limit datacase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed burial-tra Due to (or as a consequence of): Box 68760, pe Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9☐Unknown 9 ☐ Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☐ No 24a. Was an page 2 s autopsy perform certificate has 1 Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 Hospital: မ 1 ☐ Yes patient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Dath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? or Attending Natural Injury 5 Pending To the Hospital or Attenture, within 24 hours after death.

To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00058410 10-21-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PUBOX 1737 SALISMUNY UND 21802 COASTAL

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\,2007\,$ Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Year Physician SARAH BLANCHE EVANS 22,2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomica lisbu Kehab +NursingCt lisbury If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. law birthday) Social Security Number **Funeral** Months 1 □ M 2 💢 F 8-2-10 213-14-6405 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State r 28a-f show notified at 1 ☐ Yes 2 No Directo **JESTERVILLE** WICOMICO CO. MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or "natural", or Items 23a edical Examiner must b 3068 JESTERVILLE ROAD 21814 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify Specify: BLACK altimore, Maryland 21215-0036 Completed by 3√ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation of Health and Mental Hygiene. Item 27 Is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) THE HOLLY CENTER Elementary/Secondary (0-12) College (1-4or 5+) SPECIAL CARE FOSTER GRANDMOM 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GERTRUDE WINDER ပ္ NOAH DASHIELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JESTERVILLE, MD 21814 AGNES JONES DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition parvit. Pages of Decontrol of Hamon chant: If ite an Injury or of on g 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-27-07 JESTERVILLE, MD ELZIE UMC CEMETERY 22. Name and Address of Facility BENNIE SMITH FUNERAL HOME Signature uneral Service 917 W. ISABELLA STREET SALISBURY, MD 21801 Approximate Interval Between Onset and Death Part1. Enter the disease shock, or hour failure. omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (hinal disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 Due to (or as a of a quence of) Examine the death certificate be executed use as the burial-transi and (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: yes, outcome pf pregnancy
□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 ☐ Ectopic pregnancy Month for in the past 12 months? 4☐Pregnant at time of death signed by the all d be detached for ☐Yes 2☐No 9□Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Defitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rob State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 11:45P PEGGY ANN **FULKS** OCT.28,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S FORT WASHINGTON HOSPITAL FORT WASHINGTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2□F 7-29-1943 VIRGÍNIA 216-92-6285 64 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director CHARLES BRYANS ROAD MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? S A 14. Race - American Indian, Funeral 6520 MARION ADAMS PLACE 20616 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ā Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) OWN HOME HOMEMAKER <u>11th</u> permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည FRANK HOUCHINS GAY BELL BARRETT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARLTON G.FULKS-SPOUSE 6520 MARION ADAMS PL. BRYANS ROAD, MD. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State METRΦPOLITAN CREMATORY: 10-31-07 ALEXANDRIA, VA. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that outled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEVERE 0 XemI /Medical Due to (or as a consequence of) **Examiner** (y if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transi be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month Year 5 Other (specify) signed by the at d be detached fo P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an this certificate has al director, page 2 perform Cereh 1☐ Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗀 Yes Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? I or Attending F after death. Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours as To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State

Registrar

OCTOBER 29, 2007

29d, Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified

M.D. 9135 PISCATAWAY RD. SUITE 310 CLINTON, MD BASTRMOHMAD F 20735 NOV 0 6 2007

29c. License number

D 28035

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. U 2. Date of Death Month Day CARNELLE FULLER October 14, 2007 4b. City, Town, or Location of Death 4c. County of Death Upper Marlboro

/Medical Examiner

Director r then "neturel", or Items 23a or 28e-f ehow the Medical Exercines must be notified at other

death with the Marylend filed within 72 hours after thygiene. 2 should be fi and Mental F Is marked otl ages 1 and 2 sont of Health and 11 It Item 27 Is r permit. Pages 1 a
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Important: If Item:

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

the attending physician and thed for use as the burial-transit requires that the death certificete be executed be deteched this After I or Attending Fafter death. Director:

Records, P.O. Box 68760

Division of Vital

completely filled in by To the Hospital or within 24 hours a To the Funerel D

1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ERVIN 3:33 PM 4a Facility Name (If not institution, give street and number) 5605 South Marwood Blvd #314 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours Days Months 06/09/1938 1 X M 2 □ F 69 North Carolina 243-54-2540 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 □ No Upper Marlboro MD \mathbf{FG} Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5605 South Marwood Blvd #314 20772 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 years Minister Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Charlie Fuller Annie Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cecilia T. Fuller - Wife 5605 South Marwood Blvd #314; Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 10/20/2007 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee 4594 Beech Road; Temple Hills, MD 20748 polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, wone cause on each line. 23a. Part1. Ent shock, or Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Arrest Due to (or as a consequence of): Examiner Artherosclerotic Cardiovasculer Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contributa to the causa of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yas 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 9 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed? 1 ☐ Yes 2 ☐ No 1_ Yes 2 XINC 25. Was case referred to medical Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2√ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1XX Natural 5 Pending t ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death conjured at the time date and blace, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier edical (Check on ona) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Σ 29b. Signature ag e et certifie MD 20414 October 18, 2007 f person who completed cause of hth (Item 23a) (Type, Print) Georges Awah, M.D. 106 Ervin Street, N.W.

State Registrar

31. Date filed (Month, Day, Yea OCT 2 3 2007

Washington, D.C. 20010 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARY **JEAN** FLAMINI October 21, 2007 10:30 AM /Medical 4a. Facility Name (If not institution, give street and number) Nursing 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brooke Grove Rehabilitation & Sandy Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 26, 1927 6. Sex 9. Birthplace (State or Foreign PA 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 K F 80 Yrs Director 110-22-5390 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notifled at MD Montgomery Germantown 1 ☐ Yes 2 X No Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 18701K Sparkling Water Dr. 20874 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White ģ Specify: 3 ₩ Widowed 4 Divorced Completed ss 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Federal Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Streeter Marian Isham 19a. Informant's Name/Relationship (Type. Print) (Director) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 52 1018 Church Street Keller Funeral Homes Inc. Fogelsville, PA 18051 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or conce. 1 X Burial 2 □ Cremation 3 □ Removal from State St. Peter & Paul Cem. 2007 4 Donation 5 Dother (Specify) Springfield, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home ueles 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Insease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical as the IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown as been si 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform certificate 1☐ Yes 2**∑** No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ဥ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28d. Describe how injury occurred After To the Hospital or Attending (Month, Day Year 1 X Natural 5 Pending investigation death. neral Director; A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide after 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

within 24 hours a 6

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certi-

Dr.Alok Mathur M.D.

31. Date filed (Mon Day Year) 3

29c. License number

D0055694

4000 Olney-Laytonsville Road Olney, MD. 20832

29d. Date signed (Month, Day, Year)

October 22, 2007

and manner stated

32. Rajistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month October 14, 2007 Raymond H. Ferris 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Carroll Lorien Nursing Home Taneytown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2□ F 097-14-1022 April 21,1921 New York 86 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Charles Indian Head Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2815 Butterfly Place 20640 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Xes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12 Physicist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Homer Ferris Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2805 Butterfly PLace, Indian Head, Md. 20640 **Gregory Ferris** Son 20b. Place of Disposition (Name of cemetery, crematory or other place) October 19, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia Metropolitan Funeral Service 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Road, Indian Head, Md. 20640 ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, b. List only one cause on each line. 23a. Part1. Enter the se is shock, or hear fail é. Approximate Interval Between Onset and Death Immediate Cause (Firm 4/2 hemer's disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show notified at

an "natural", or Items 23a or Medical Examiner must be

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permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If item 27 is marked other tha any injury or other traumatic event, the 1 once.

Maryland 21215-0036

Baltimore.

P.O. Box 68760

Division or Vital Records,

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1 ☐ Yes 2 ☐ No

examiner?

1 Natural

2 Accident

3 Suicide

4 Homicide

29b. Signature and title of certifier

A

IF FEMALE:

performed? Yes 2⊡No 1∐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

10-17-07

25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury

27. Manner of Death 5 ☐ Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 SertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TATE

TANEXTOWN, MO 21787 29. Frederik

43643

Registrar

32. Resistrar's Signature 31. Date filed (Month, Day, Year) OCT 2 3 Goarde 2007

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		State of Maryland / Department of Health and M Certificate of Death		giene (7 35612
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Phys /Me	ıçıan dical	CAREY L. FIELDS	10	17	07 2040
	niner	4a Fecility Name (If not Institution, give street end number) 4b. City, Town, or Lo			
		MCCREADY HOSPITAL CRIST			MERSET
Funer		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. Months Deys Hours Min.	8. Date of Bir	y, Year)	9. Birthplace (State or Foreign Country)
Direct	or .	Usuel Residence of Decedent	83	1-62	71(0
ylend ***		10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
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ath w	Funeral Director	58 SOMERSCOVEHPTS 21817		US	• • • • • • • • • • • • • • • • • • • •
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120 13 eft	by F	Mever Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: Year or Dates:		Specify	BLACK
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De file	Be Completed	17. Fether's Neme (First, Middle, Last) 18. Mother's Name	1		
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Balt permit. Depent importa	8	\ (\lambda \cdot \	S. S.	10.24	112 2191
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Physicia	n	shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
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Rec e law hes t	d E				of death?
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ivisite de l'inecto	THE STATE OF	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To		er or Rural Route Number,
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	tate	31. Dete filed (Month, Dey, Year) OCT 2 2 2007	. 0, (1 00 1)	1 010121	
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Charles O Fruhli		State of Maryland / Department of Health and Mental H		g. No. 2007 35613
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Deat	h 3. Time of Death
Medical Exami		Charles Otto Fruhling	Month October 25	
y " "		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat 1003 Pulaski Highway Joppa	h	4c. County of Death Harford
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	s. 8. Date of Birt	th(MM/DD/YYYY) 9, Birthplace (State-or
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Maryland 28a-f show	ģ	Maryland Harford Joppa 10e. Street and Number 10f. Zip Code	10	Og. Citizen of What Country?
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene a ment of Health and Mental Hygiene a new 1 firem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		- 14. Race - American Indian, Black,
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5-0036 Jed within 7 Hygiene. I other than	ပ္ပ	17. Father's Name (First, Middle, Last) 18. Mother's Nam	ne (First, Middle, N	Maiden Surname)
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Baltimore, MD 21215-003 permit Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med	ပ	19a. Informant's Name/Relationship (Type, Print) Shirley Fruhling / Wife 19b. Mailing Address (Street and Number or 1003 Pulaski Highway)		Maryland 21085
e, M and 2 Tealth item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or Town, State
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Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cau	se(s) and manner as stated. and place, and due to the cause(s)
To tl withi To tl	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
	_	Dama minanti, mit. O.C.M.E.		October 25, 2007
		30. Name and address of person who completed cause of death (Item 23a)		
		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201	
S Regis	tate trar	31. Date filed (Manth, Dan Year) 2007 Registrar's Signature		

Registrar

DHMH 17 Rev 1/2001

State

Dr. Mark Parkhurst

31. Date filed (Month, Day, Ye)

32. Registrar's Signature

10.

3110 Gracefield Road, Silver Spring, MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 7:05 АМ Kitty Lee Godlove October 0 20 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood At Williamsport Washington County Williamsport If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1 □ M 2 🔏 F Days Months 220-16-3914 81 Director 30 1925 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Framina. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 No Director Maryland Washington County Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Ave. 21795 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Packing Clerk Toy Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester LeRoy Smith ၉ Mary Sypoit 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James F. Godlove, Jr.-son 14731 Cearfoss Pike Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or othe place) 20a. Method of Disposition 20c. Location - City or Town, State Bunal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland Cedar Lawn Memorial A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1331 Eastern Blvd North Hagerstown,MD 21742 23a. Part1. Enter the disease per complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** to joscie /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 4☐Pregnant at time of death Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Certification: To 1 ☐ Yes 2 No Other: 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Natural Accident hours after death. 1 Yes 2 🗌 No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examination the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certi-

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** James Nicholas Giordano 2007 10:30 P M October 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday **Funeral** 1**X**M 2□F 217-24-4360 78 Director Aug. 4, 1929 New York Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at Y Yes 2 No Maryland Carroll Director Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country a or 3871 Yellowstone Court 21074 ms 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 O.E. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or items 11. Marital Status 1950-Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: White 1951 <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) overland than Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other thar other traumatic event, the M truck driver transport 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicholas Giordano Elsie Drake 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Giordano - wife 3871 Yellowstone Court Hampstead, Maryland 21074 : If Item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date يّ20 **,** 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or Hampstead, Maryland Carroll Cremation 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Lice M01072 934 South Main Street Hampstead, Maryland 21074 unus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last te pulving orsense Examine The law requires that the death certificate be executed sician and burial-trans physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: after death. Director: After this certific in by the funeral director, 25. Was case referred to examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To Other (Specify) 27. Man Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospital within 24 hours a To the Funeral Completely filled filled Certifying Physician: To th best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical asis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 Medical Examine and ma nner stated

WSL

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Wear OCT 2 3 2007

GAFFAF

29b. Signature and title of certifier

30. Name and address



29c. License number

South CENTER STREET WESTHINSTER HD 2115

29d. Date signed (Month, Day, Year)

			1 - State Registrar	State of Ma	aryland		rtificate of			Reg. No	2007	35617
	Physicia		Decedent's Name (First, Middle, L	CHARLE:	S HAL	LER GO	SNELL				2007 2007	3:24 PM
	/Medic Examin		4a. Facility Name (If not institution, ga	ive street and number)		**	**	r Location of Death		4c	. County of Deat	
		J.	Northampton Manor				Freder		Lo Bata et Bist		rederick	
ak 15	Funeral Director		5. Social Security Number 6. 217–18–8526 Usual Residence of Decedent	Sex 7. Age	86	est birthday) Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da Aug . 23	Year)	921 Mai	nplace (State or Foreign untry) Cyland
	/land low at		10a. State 10b. County		10c. City.	, Town or La	cation				,	10d. Inside City Limits
	e Man a-f sh tified	ctor	Maryland Freder	ick	Fr	ederi	ck					1 ∏Yes 2 No
	or 28	Directo	10e. Street and Number	1 0			10f. Zip Code	21701		10g. Ci	tizen of What Co	
	eath v is 23a must	Funeral	200 East Sixteent	12. Was Decedent	Ever in U.S	S. 13.			pecify Yes or No	T	14. Race - Ame	
paritiniore, Mar ylaring Z 1 Z 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		by Fun	1 Marriad Status 1 Mever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? X Yes 2 1 If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub 1□Yes 2XNo		o Rićan, etc.)		Black, White Specify: White	
ה ה	72 ho	Completed	15. Decedent's (Specify only highest g	Education trade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	ation during most of wor	rking	16b. K	Kind of Business/	Industry
V	vithin "	mple	Elementary/Secondary (0-12)	College (1-4or 5	i+)		DO NOT use retire sembly Li	•		А	ssemb1y	
Z Z	filed v Hygid Hygid other i		17. Father's Name (First, Middle, Las	st)		210	Jemory 11		ne (First, Middle,			
0	uld be dental rked c tic ev	To Be	Ralph McKinsy Go	sne11				Lucy H	aller			
Mary	ind 2 shou alth and N 27 Is mai er traumai		19a. Informant's Name/Relationship Helen Gray / Si				ng Address (Street New Wind					
ย์	es 1 a of Hei of Hei fitem		20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3	☐Removal from State			osition (Name of matory or other pla		Date		ocation - City or	
Dallillion	Pag tment tant: I		4 ☐ Donation 5 ☐ Other (Spec	M	Mour		vet Cem.	i .			-	Maryland
סמ	permit Depar Impor any In once.		21. Signature of Funeral Service Lib	Sea		- 1	OBERT E. 201 NORTH	MARKET	SI., FKI	LDEK	L HOMES	21/01
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each li	I the death ne.	. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Due to (or as	pne	21m	prior					/ Wep/s
	Examiner			Due to (or as	a consequ	erice or).						
. 4	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):						
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26/00,	ficate be executed physician and s the burial-transit	edical E		d	·	,						
_	ng ph	Medi	IF FEMALE:				_					
, box	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у			23d. Date of de Month	livery Day Year
л Э	requires that the een signed by th nould be detache	Phy	9 ☐ Unknown Part II. Other significant conditions		ut not recu	Iting in the	inderlying cause di	ven in Part I	23e Did I	tohacco	use contribute to	o the cause of death?
g,	signer d be d	þ	Part II. Other Significant conditions	contributing to death b	di noi resu	ining in the c	inderlying educe gr	VOIT II T GIV II	1 🗆			robably 4 Unknown
ecoras		letec							24a. Was	an	24b. Were a	utopsy findings available
r	sician: The law s certificate has t irector, page 2 s	Completed							auto perfo 1∐ Yes	psy ormed? 2 N	death?	completion of cause of 2 □ No
N II a	stan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?					. /	ath (Check only	1		
) 	> .∞ 0	To	1 ☐ Yes 2 No			ER/Outpatie	nt 3 DOA				6 □Other (Spe	ecify)
	Ilng After fune	ion:	27. Manner of Death 1 Natural 5 Pending investigat	28a. Date of Inju (Month, Da		28b. Time of Injury	Wo	ıry at ırk?]Yes 2∐No	28d. Describe	how inju	ury occurred	
JIVISION	Attender death	Certification:	2 \rightarrow \text{Accident} \text{investigation} \text{Could not} \text{determine} \text{determine} \text{determine} \	be 280 Place of ini	ury - At ho c. (Specify	me, farm, st	reet, factory, office		28f. Location (City or To	Street a	and Number or R te)	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Ce	29a. Certifier Certifying (Check only one) Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	f examinat	tion and/or in	vestigation, in my	opinion, death occ	urred at the time	, date a	nd place, and du	e to the cause(s)
	ro the vithin го the	Mec	29b. Signature and little of certifier				29c. Licen	se number		29d. D	ate signed (Mon	th, Day, Year)
ļ			AN -	Hiran	2 3	Sha	L D5	1643		10	-23-0	th, Day, Year) 7 m) Cox 2/202
1	+114+		30. Name and address of person wh	no completed cause of c	leath (Item	23a) (Type	Print)	Rain	n		2-1-	110
7	Sta	ite [®]	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture ture	mas	Jonse	01		ofen	UK OUT HEL
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Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760

Registrar

MEINDERT

M. D. 12070 OLD LINE CENTERE #100 WALDORF, MD 20602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cours.

SMITH,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last)
Paul Registrar 2. Date of Death Physician/ Edwin Hartman 2009 hrs Medical Examiner October 31, 2007 c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown Washington County Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Penna. Hours 4/20/1931 Director 217-28-5032 76 Country) 1 X M 2 F Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any 10a, State 10b. County 1 Yes 2 X No Williamsport 28a-f show MD. Washington death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number C-62 16505 Virginia Ave. 21795 U.S.A. items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? 1 Never Married 2 X Married 1 X Yes 2 White Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", o Yes 2 X No specify: Specify: 3 Widowed Divorced If Yes, Give Yea ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Credit Service President/Owner 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kellar Hartman Esther V. Shipp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4505 Cornflower Court Ellicott City, Md. 21043 Randall Hartman /Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mercersburg Pa. Montgomery Church Cemetery 11/5/07 Donation 5 Other Specify ury or 2 Name and Address of Facility 7 immerman And Son Funeral Home 45 S. Carlisle St. Greencastle 21. Signature of Funeral Service Licenses Home Inc. 23a. Part I. Erner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Acute Coronary Artery Thrombosis Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): b. Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and the detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available After this certificate has been autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) I Director: After this certifed in by the funeral director, Be Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Other4 DOA Nursing Home 5 Residence 6 Other: 1 V Yes 2 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural Yes 2 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide or Town, State) determined Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifie November 1, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 16 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State MOV 0 6 Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:30 P_M October 29, 2007 Physician Elaine Andoris Heiberg /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Year) April 18, 1919 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 474-14-1522 7. Age (In vrs. last birthday) 6 Sex **Funeral** Country) Minnesota Months Days Hours 1 □ M 2 🕅 F 88 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must he matter and once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Maryland Frederick Frederick 1 X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 121 Record Street 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personnel Officer Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gerda Clarissa Olson Andreas Severin Heiberg ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara O'Neil Clary / Friend 5519 Jefferson Blvd. Frederick, MD 21703 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory November 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg, Maryland 5, 2007 4 □ Donation 5 □ Other (Specify) Keeney & Basford P.A. Fi 106 East Church Street, 21. Signature of Fuperal \$ Funeral Home t, Frederick, M01433 MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r, spiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dav F) Cut E myoca dal Inflaction disease or condition resulting in death) /Medical Due to (or as a consequen) of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760. Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2**X** No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an has certificate 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and tital of certifier

Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

honson

istrar's Signature

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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Gloria Lavonne Harp 26, 4:26 P October 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20 Harp Place Unit #A Myersville Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🖾 F 79 220-26-7366 Director Dec. 14, 1927 Maryland Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TYes 2 No Director Frederick Maryland Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 20 Harp Place Unit #A 21773 U.S.A.r than "natural", or items 23a the Medical Examiner must Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul W. Garver Florence Hollinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Harp Place Unit #B Myersville, Maryland 21773 Edwin Nikirk (Grandson) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Smithsburg Crematory 2, 2007 Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J.L. Davis Funeral Home 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. Smithsburg, Maryland 21783 MO1414 DAVIS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATherosciepe FC CARDIOVASCINIM Physician US CARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physician and sthe burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an certificate has autopsy performed? 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) မ 1 🗌 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3□ DOA this funeral 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: For the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and g address of person who completed cause of death (Item 23a) (Type, Print) 30 Name and SMITUBLEY, MD um av D 0 22911 31. Date filed (Month, Day, Year) egistrar's Signature NOV 0 6 Registrar

Division or Vital Records, P.O. Box 68760

Fo the Hospital or Attending Physician: the

State Registrar

Medical

6 ☐ Could not be

determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day,

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 35623 Michael Francis Hoffman Certificate of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 21, 2007 0950 hrs al Examiner Michael Francis Hoffman 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Riverdale 5907 Cleveland Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country DC Months Days Hours Director 217-44-3239 Apr 5, 1946 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No Riverdale Maryland Prince George's or items 23a or 28a-f sho must be notified at once. 2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene. Directo 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 5907 Cleveland Avenue 20737 USA 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Never Married 2 K Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No Specify: White If Yes, Give Yeer Yes 2X No specify: Divorced Widowed Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Government Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Printer Printing Office 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be traumatic event, Joseph F. Hoffman, Sr. Emma Lane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charlene Hoffman - Wife 5907 Cleveland Ave., Riverdale, MD 20737 Pages 1 and 2 s nent of Health ar If item 27 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date ltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 10/23/07 Alexandria, Virginia Inportant: Donation 5 Other Specify 22. Name and Address of Facility 4739 Baltimore Ave. 21. Signature of Funeral Service Licensee Gasch's Funeral Home, P.A. Hyattsville, MD 20781 201491 23a. Part I. Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. 'Medical Death a. Intraoral gunshot wound Immediate Cause (Final disease xaminerگ or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical UNPENDED AMENDED the attending physician ed for use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) detached for Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S 1 Yes 2 ✓ No 3 Probably 4 Unknown pleted 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has death? performed? No page ✓ Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital the funeral director, Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene this 1 ✓ Yes No 28a. Date of Injury (Month, Day, Yeer) FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject shot self Certification FOUND: Division Natural Pending Yes 2 V No Director: Oct 21, 2007 0944 hrs 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 5907 Cleveland Avenue, Riverdale, MD (Specify) Single Family determined

State

29a. Certifier 1

29b. Signature and title of certifie

Jash

Medical

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Tasha Greenberg MD.

wo

and manner stated.

32. Registrar' Signatu

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 22, 2007

OCME

07-08391 Franklin Henry Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 35624

2111(11) 1	,	R	- For State	Certificate o	f Death			2 U U		
P. edical	hysicia Examii	ın/	1. Decedent's Name (First, Middle,Last) FRANKLIN DELANO HENRY				Date of Death Month October 28	Day Year	3. Time of Death 1106 hrs	
Caicai	_xa		4a. Facility Name (if not institution, give street and number)		• • • • • • • • • • • • • • • • • • • •	Location of Death		4c. County of Deat Charles	n	
-			2625 Butterfly Place 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	Indian Head		8. Date of Birth	(MM/DD/YYYY) 9. Bi	rthplace (State or	
	uneral rector		217-44-2698 1XM 2_F	62 Yr	Months Day			Forei	gn WASHINGTON, buntry) DC	
	any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca	ation				10d. Inside City Limits	
and		ъ	MARYLAND CHARLES	INDIAN HEAT					1 Yes 2 X No	
10958 hours after death with the Maryland	23a or 28a-f show notified at once.	Dire	10e. Street and Number 2625 BUTTERFLY PLACE		10f. Zip Code 20	640		10g. Citizen of What Country? UNITED STATES		
death with	r items 2. nust be n	Funeral		No If	as Decedent of Hi Yes, specify Cuba	in, Mexican, Puerto		White, etc.	rican Indian, Black,	
after	ral", o iiner n	by F	3 Widowed 4 Divorced If Yes, Give Year 196 or Dates:		Yes 2 X No		work done	Specify: BLAC		
2 hour:	"natu I Exan	g	15. Decedent's Education (Specify only highest grade com- Elementary/Secondary (0-12) College (1-4 or 1	during	most of working life			COVERNMENT	OF THE	
VID 21215-0036 2 should be filed within 72	r than fedica	Completed	12TH GRADE	FIRE	FIGHIER			DISTRICT OF	COLLIMBIA	
215-0036 be filed within 7	and Mental Hygiene. 7 is marked other th		17. Father's Name (First, Middle, Last) WALTER S. HENRY				e (First, Middle, M GS HENRY]	Maiden Surname)		
212	Mental I marked c event,	To Be	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Stre			nber, City or Town, Sta	te, Zip Code)	
MD d 2 sho	Health and N iten: 27 is n r traumatic		JOY HENRY / DAUGHTER					AND 20640 20c. Location - City	or Town State	
u, e			20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from St	20b. Place of Disposate crematory or o	other place)		Date			
Baltimore,	Department of I		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	MARILAND V	. Name and Addres			CHELTENHAM,		
Bal	Depart Impor injury	Ų į	LADIA C. THORNION JOHNSON, MOO58			STON ROAD,	INDIAN HE	NERAL HOME, I AD, MARYLAND	20640	
	/sician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	I the death. Do not enter	r the mode of dying	g, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and	
	l dical	20 Y	Immediate Cause (Final disease a. Hypertensiv	e cardiovascu	lar diseas	e and pneur	nonia		Death	
			or condition resulting in death) Due to (or as a cons	equence of):						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	equence of):						
		Examin	(Disease or injury that initiated events resulting in death) Last	sequence of):						
bettited	and - transit		d.							
'60,	cate of execut physician and he burial - tra	Medical		TI.27.perME.G	873, 11/7/	07_TT		23d. Date of deliv	rery	
3876	fing phy	an/N	23b. Was decedent pregnant in the	2	Fetal death 3	3 Ectopic preg	nancy	Month	Day Year	
Box 687	attence for use	/sician/	1 Yes 2 No 9 Unknown g Unknown	at time of death 5	Other (Specify)					
О.	Attending Physician: The law requires that the ocall certure redeath. refort. After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as it by the funeral director, page 2 should be detached for use as it by the funeral director.	/ Phys	Part II. Other significant conditions contributing to dea	th but not resulting in th	e underlying cause	e given in Part I.			to the cause of death?	
, P.O	irres tinat i signed l d be deta	ed by	Chronic alcoholism				1Ye		robably 4 V Unknown autopsy findings available	
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Rec	ctan: The law rector, page 2 sh	E			OC Die	ace of Death (Che		2 No 1 🗸	Yes 2 No	
ital	sictan: is certii irector	B B	25. Was case referred to medical examiner?	ient 2 ER/Outpatio		Othor	sing Home 5	Residence 6 🗸 O	ther: Scene	
of V	Img Fhysician: After this certiff funeral director,	1.7	1 Yes 2 No 28a. Date of In (Month, Day	jury 28b. Time	of Injury 28c. Ir	njury at Work?	28d. Describe	how injury occurred		
ion	tendin leath. tor: A	를 를	1 X Natural 5 Pending			Yes 2 No			David Nambar City	
		Certification:	3 Suicide 6 Could not be determined (Specify)	Injury - At home, farm, s	street, factory, offic	e building, etc.	28f. Location or Town,		Rural Route Number, City	
Δ.	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in		29a. Certifier 4 Certifying Physician: To the best of	my knowledge, death or	ocurred at the time,	, date and place, a	ind due to the cau	use(s) and manner as	stated.	
	To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner states	amination and/or invest	igation, in my opin	ion, death occurre	d at the time, date	e and place, and due t	o the cause(s)	
	- ≤ - 3	Me	29b. Signature and title of certifier			ense number C.M.E.		29d. Date signed October 29, 2		
			hy hi, hid	Educatio (Harra 2004)		O.1VI. L.		00,000, 20, 2		
TR	IVA		30. Name and address of person who completed cause of Ling Li, MD Assistant Medical Examin	er 111 Penn St	reet, Baltimor	e, MD 21201				
	5	State	31. Date filed (Mont) (Mont) (27) 1 2007 32. Regist	rar's Signature	Joseph					
	Regis			was No L	TANKEL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Margaret J. Hyde 10 23 2007 4:55 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Long View Nursing Home Manchester Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🟋 217-20-2767 88 Director Maryland 12/08/1918 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □ Yes X□ No Manchester Carroll Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21102 United States 3289 Charmil Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department Store Sales Representative is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret McDowell Arthur Durham other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is I 3289 Charmil Drive, Manchester, Maryland 21102 Arthur A. Starkey - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Carroll Cremation 10/25/2007 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eline funeral Home 934 South M01490 Bna Main Street Hampstead, Maryland 21074 1 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. E. Hef Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 \(\sum \) Yes 2 \(\bar{\mathbb{E}} \) No 3 ☐ Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9☐ Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has funeral director, page 2: autopsy 1∏ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 🔲 Yes 2**1**] No 2 ER/Outpatient 1 ☐ Inpatient Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 5 ☐ Pending investigation 1 Natural Injury death, 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Puneral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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WILD

State Registrar 31. Date filed (Month, Day, Year)

30. Name and ad

C'ton M D

32. Registrar's Signature

ress of person who completed cause of death (Item 23a) (Type, Print)

OCT 2 4 2007

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Westing in ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physici		Margie Jane	Hett	Oct 16	Day Year 2007	11:45 P ^M
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	111.43
44	xaiiiii	Ü	1805 Bloom Road	Westminster		Carroll	
0° - 28'-	Funeral Director		5. Social Security Number 6. Sex $1 \square$ M $2XXF$ 7. Age (In yrs. last birthd Yrs	Months Days Hours Min	8. Date of Birth (Month, Day, Yes	1935 9. Birthr	place (State or Foreign ntry) ryland
	pu ,		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or	Location			10d. Inside City Limits
	aryla shov	٦		minster			1 ☐ Yes XIXNo
	the M 28a-f otifie	ect	10e. Street and Number	10f. Zip Code	100	Citizen of What Cour	
	be filed within 72 hours after death with the Maryland tial Hyglene. ad other than "natural", or items 23a or 28a-f show event, the M. dr al Examiner must be notified at	Funeral Director	1805 Bloom Rd.	21157	Ü	nited St	ates
	items	nue		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	ir; or xamir	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Whi	te
Ö	72 hou 'natura dical E		15. Decedent's Education 16a. De	cedent's Usual Occupation	. 16b	. Kind of Business/In	dustry
215	within 7 iene. than "n the M di	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	tive kind of work done during most of work e. DO NOT use retired)			
2	filed wi Hygien other th	ا ا	001	emaker		er home	
Maryland 21215-0036	the filed intal Hygie ed other:	Be	17. Father's Name (First, Middle, Last) Howard L. Colson, Sr	Annie D	e (First, Middle, Maid uvall	len Surname)	
Ž	2 should be f and Mental I is marked of raumatic eve	٦		ailing Address (Street and Number or Rui		ty or Town, State, Zig	o Code)
S	ロギビュ			Bloom Rd. West			
J.	ss 1 a of Hez item	18	20a. Method of Disposition 20b. Place of Disposition cemetery,	sposition (Name of crematory or other place)	Date 20c.	. Location - City or To	own, State
Ē	Page nent c		I Buriai 2 Acremation 3 Hernoval from State	coll Crematory 1	0/20/200	7 Winfie	eld, MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Litensee	22. Name and Address of Facility urrier—Queen Funera 212 W. Old Liberty	al Home and	d Cremato	ry, P.A.
No.	四 號人	1	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CANCER		1	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				J
	LAdillillei	L.	Sequentially list conditions, b.				
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury				
	execu and al-trai	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):		-		
8760,	icate be executed physician and s the burial-transit	dical E	d				
ထ	tificat g phy as the	ledio	- V.				
Box	leath certific attending p	M/M	IF FEMALE: 23b. Was decedent pregnant in the cost 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death	3 ☐Ectopic pregnancy		23d. Date of deliv	,
	the death certificate be executed y the attending physician and iched for use as the buriat-transit	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death	5 Other (specify)		Month	Day Year
P.0	that the de led by the a detached t	Phy	9 LI Unknown	a undankina asusa siyas is Dad I	220 Did tehana	a una contributa ta t	the sauce of death?
Division or Vital Records,	sigr d be	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	1 XYes	co use contribute to t	bably 4 ☐Unknown
900	law requas been 2 should	Completed			24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
ř	(0 L)	E O			performed	? death? No 1 \(\sum Yes\)	2 □ No
ita Ita	rysician: Th iis certificate director, pag	Be (25. Was case referred to medical examiner?		h (Check only one)		
2	dir ys	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			e 6 □Other (Speci	fy)
n C	ling F I. After funera	ion:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending (Month, Day Year)		28d. Describe how in	njury occurred	
<u>s</u>	Attending r death. ector: Aftel by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, farm	_	28f. Location (Street	t and Number or Bur	al Boute Number.
2	after (Direct Direc	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Si		
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier Certifying Physician: To the best of my knowledge, c				
	he H(in 24 he Fu pletel	edical	(Check only one) Medical Examiner: On the basis of examination and/one) and manner stated.	or investigation, in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)
	To the within 24	Ň	29b. Signature and title of certifier	29c. License number	1	Date signed (Month,	
	2		· (N/Larocore	100240	//	7.17.0	//
1	MA		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) H Washington H1		101	1 , 2115
	(0		Natvarial Kajpara, M.D. 22 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	1 Washington Ht	3, Medical	ur., w	lestminster, M
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 2 2007	Sparte			

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			State of Maryland /				Mental Hy		007	25	627
			1. Decedent's Name (First, Middle, Last)	Cen	ificate of l	Death	2. Date of D		007		
3	Physici		Mary Virginia Hurley				Month OGOS	Day	Year	0	of Death
	/Medio		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Dea			ounty of Death		.,,
	2,4		Baltimore-Washington Medical Cen	ter	Glen B	urnie		Ani	ne Arun	idel	
8	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last I	birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, D	rth ay, Year)	9. Birth	place (Stat	te or Foreign
к	Director		Usual Residence of Decedent	Yrs.			Jan 9,	1918	West	t Virg	ginia_
	yland now at		10a. State 10b. County 10c. City, To	wn or Loca	ation					10d. Inside	City Limits
	e Mar la-f st tiffed	ctor	MD Anne Arundel Pasad	.ena						1 □ Y	es 2 No
	or 28	Dire	10e. Street and Number		10f. Zip Code			10g. Citize	en of What Cou	intry?	
	d within 72 hours after death with the Maryland giene. rr than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Funeral Director	218 Lake Road	10.14	21122		0	USA	Dana Amar	ioon Indian	
	fter de	Fun	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Ves 2 ∑ No	if	as Decedent of Hi Yes, specify Cuba	ispanic Ongin? (in, Mexican, Pue	rto Rican, etc.)	0- 14	 Race - Ameri Black, White 		
215-0036	ours a ral", o Exam	þ	3 ☑ Widowed 4 ☐ Divorced If ☑ Sear or Dates:	1[□Yes 2XX No	Specify:		S	Specify: Whi	ite	
ر ک	72 hc 'natu	Completed	15. Decedent's Education 16 (Specify only highest grade completed)	3a. Decede	nt's Usual Occupa ind of work done of O NOT use retired	ation during most of we	orking	16b. Kind	d of Business/Ir	ndustry	
7	within ene. than '	dm	Elementary/Secondary (0-12) College (1-4or 5+))	Ü	0h 4	- / C + - +-	:	
7	filed Hygi ther int, t	ပိ	17. Father's Name (First, Middle, Last)	aresp	erson	18. Mother's Na	ame (First, Middle		a/Stati Gurname)	Lonary	7
yland	0 = 0 =	To Be	W.D. Merchant			Bessie (Cain		,		
Mary	2 should be and Menta is marked raumatic ev				Address (Street a				Town, State, Zi	p Code)	
Σ (and 2 ealth m 27				ike Road			.122			
saltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.				tion (Name of atory or other plac		Date		ation - City or T		
	it. Pa intmer intant: njury		4 □ Donation 5 □ Other (Specify) Chesa 21. Signal e f Funeral Service Licensee	-	Cremato	-		1	ville,		
g	Deps Impo		13. all VII 12.		Name and Addres						01000
*			23a. Part1. Enter the disease, or complications that caused the death. Dishock, or heart failure. List only one cause on each line.	o not enter	erly L. the mode of dyin	Heckrot g, such as cardi	ac or respiratory	CLar arrest,	KSVILLE	Approxim Interval B	
	Physician		Immediate Cause (Final disease or condition	Br	EAST					Onset an	id Death
<i>(</i> -	/Medical		resulting in death) a: Due to (or as a consequence	e of):	CASI	C)					
	Examiner	_	Sequentially list conditions, b.								
ī	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause).	e or):							
.	execuna and ial-tra	Exa	resulting in death) Last c Due to (or as a consequenc	e of):							
8/00,	ficate be executed physician and sthe burial-transit	dical									
0	certifica ding ph se as th	Med	IF FEMALE:					- 1			
Ö	w requires that the death certif been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea		ctopic pregnancy			23	d. Date of deliving Month	very Day	Year
	the de y the a	ysic	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 🗆 (Other (specify)				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-uy	
τ <u>.</u>	that the part of t		Part II. Other significant conditions contributing to death but not resulting	j in the und	erlying cause give	en in Part I.	23e. Did	tobacco use	e contribute to	the cause o	of death?
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		Som					auto perf 1□ Yes	ormed?	death?	2□ No	r cause or
2	slcian: The law certificate has b irector, page 2 s	Be (25. Was case referred to medical examiner?		Low		eath Check onl	one			
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5	tal or rs after al Direction	Certification:						wn, State)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination a	lge, death o and/or inve	occurred at the timestigation, in my o	ne, date and plac pinion, death occ	ce, and due to the curred at the time	cause(s) a	nd manner as	stated. to the caus	e(s)
	o the ithin 2 o the	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. License				signed (Month		
	7 8 4 8		MA hours	mi	Da	514	i	00	Ther	23	2007
9	3	1	38. Name and address of person who con-leted cause of death (item 23a	ı) (Type, Pı	int)	0.	0			117	
9	9		Chabajo 301 Hospita	0 1	mve	Glen	Burs	ue	MIS	201	61
	Sta Registra		31. Date filed (Monte 1) 2 4 2007 32. Tegistrar's Signature	1	all 1						
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State Registrar

DHMH 17 Rev 1/2001

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Month Year **Physician** 1:30 am October Bernard Bela Jacobi 22 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours Min. 1 X M 2 □ F Director June 1, 1914 Czechoslovakia 117-05 7278 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at 28a-f show 1 ☐ Yes 2K No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7828 Maryknoll Avenue 20817 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) System Analyst United States Government 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herman Jacobi Helen Friedman P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita M. Jacobi - Spouse 7828 Maryknoll Avenue, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State d 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Gardens 10/23/2007 Falls Church, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Ŧ ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ire. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the shock, or he Immediat use (Final disea r condition resulting in death) Physician 10 days Respiratory Failure /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia 10 days Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ig physician and as the burial-trar Due to (or as a consequence of): アールの名子、ひらんが飛び Division or Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.

When the Funeral Urctor: After his certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hypoalbuminemia 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Clostridium Difficile autopsy 2 ☐ No 1 Yes 2 No 1 ☐Yes Failure to Thrive 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 X Inpatient 3□ DOA 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 🗷 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) D 0043904 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theo Heller MV Suburbain Hespital 8600 Old Georgetown Read Bethe Sta MD 120814 31. Date filed (Month) 32. gistrar's Signature 23 2007 State Registrar

			For State	State of Ma	aryland /	Depa	artment of H	lealth a	nd Me			7 3563	30
70×10	_		Registrar	Locati		Cei	Tillicate of I	Deam	2	Date of Dea	eg. No.	3. Time of Dea	ath
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	/Medic		Whitney 4a. Facility Name (If not institution,	give street and number)	Jones		4b. City, Town, or	r Location of		ctober)	4c. County of		A
	Examin	er	12494 Walnut Gr				German		i Deaii		Montgo		
9	Funeral			6. Sex 7. Age	e (In yrs. last t	oirthday)	If Under 1 Year	If Under 2		Date of Birth	1 9	Birthplace (State or Fo	reign
	Director		242-49-8892	1□ M 2∏ F	21	Yrs.	Months Days	Hours	Min.	(Month, Day pril 2		Country) Iorth Caroli	ina
	D .		Usual Residence of Decedent										
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	he M 8a-f otifie	ecto		omer)		·					Oa. Citizen of Wha		
	a or 2	ä	10e. Street and Number 12494 Walnut G	morro Cimalo			10f. Zip Code 2087					,	
	eath	Funeral Director	11. Marital Status	12. Was Decedent I	Ever in U.S.	13.1			nin? (Specif	v Yes or No-	United 14. Race -	American Indian,	
_	iter d	ᇤ	1 XNever Married 2 Marrie	Armed Forces?		10.	Was Decedent of H If Yes, specify Cuba	an, Mexican,	, Puerto Rio	can, etc.)		White, etc.	
20	urs al	þ	3 ☐ Widowed 4 ☐ Divorced	if Yes, Give Year or Dates:			1 □ Yes 2 汉 No	Specify:			Specify:	Black	
2-003e	72 ho	Completed	15. Decedent' (Specify only highes	s Education	16	a. Dece	dent's Usual Occup	ation	of working	1	16b. Kind of Busin	ness/Industry	
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7	ed wi ygien yer th	ပ္ပ	0			Non	ie – – –				None		
and	be fill d oth	Be	17. Father's Name (First, Middle, L	.ast)							Maiden Surname)		
y a	ould Men Marke Marke	ဠ	George Jones		1					nkins			
2	d 2 sh h and 7 Is n traun		19a. Informant's Name/Relationsh Sharon Jones				ng Address (Street						
ค _	1 and Healt em 2		20a. Method of Disposition	(mother	,		4 Walnut osition (Name of matory or other place		Date		20c. Location - Ci		
baltilmor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☑ Burial 2 ☐ Cremation		1	•	matory or other plac ark Cemet	· ' ' '	Oct.	21,		sboro, NC	
	artme		4 □ Donation 5 □ Other (Sp.		Carve				2007			-	
D D	permit Depar Impor any In once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park DrGaithersburg, MD										
۰			23a. Part1. Enter the disease, or	complications that caused	d the death. De	_						Approximate	
	Physician		shock, or heart failure. List of Immediate Cause (Final	•	^{ne.} 1 Failu	ira						Interval Between Onset and Deat	ith
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	Examiner												
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×	ding se as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						23d. Date	of dollyon.	
200	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		☐Ectopic pregnancy ☐ Other (specify)	у			Month	•	ır
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io no	Ing P		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Date	ıry 28b ıy Year)	o. Time o Injury	Wor			d. Describe h	ow injury occurred	d .	
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N	il or Attending Physician: after death. L'inector After this certification by the funeral director.	Certification:	4 ☐ Homicide determi	nod Zoe. Flace of Hije	c. (Specify)	iarm, su	reet, factory, office		281	City or Tow	n, State)	or Rural Route Number,	Γ,
-	polital curs a leral filled		29a. Certifier 1 X Certifying	g Physician: To the best	of my knowled	lae. deat	th occurred at the ti	me. date an	d place, an	d due to the o	cause(s) and man	ner as stated.	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director. After this certificate he completely filled in by the funeral director, page	edical		Examiner: On the basis of and manner sta	of examination								
	To th To th comp	Me	29b. Signature and title of certifier	1. m	_/		29c. Licens	e number		- 1		(Month, Day, Year)	
	3		Denoncia	wholeler	W5/4	hy) D00	064615	ó	C	ctober 1	.8, 2007	
			30. Name and address of person v	•									
			Genevieve Wrob		- 1355	Picc	ard Drive	e – Ro	ckvi1	1e, MI	20850)	

Registrar

DHMH 17 Rev 1/2001

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32. Repistrar's Signature

32. Repistrar's Signature

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. 7	Physici	an	Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	_	Shirley	Ann		Jones		10 2	22 2007	, 5.00
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County of Dea	
(a) (a) (a)			5310 Powellville 5. Social Security Number 6.5		In yrs. last birthday,	Pittsvi	11e	8. Date of Birth	Wicomico	
	Funeral Director			I □ M 2 💢 F	7.5 Yrs.	Months Days	Hours Min.	(Month, Day, 1 3-12-193		thplace (State or Foreign ountry) vland
	1.00		Usual Residence of Decedent					3-12-193	oz mar	yrano
	rylan	_	10a. State 10b. County	1	0c. City, Town or L	ocation				10d. Inside City Limits
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	with th	Die	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	e 23a	erai	5310 Powellville	Road 12. Was Decedent Eve	orin H.S. 12	21850 Was Decedent of His		oity Voc or No	USA 14. Race - Am	orican Indian
36	tges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Examinat must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cubar 1 ☐ Yes 2 No	Specify:	Rican, etc.)	Black, Whi	
21215-0036	72 hou	Completed	15. Decedent's E (Specify only highest gr.	ducation	16a. Dece	edent's Usual Occupa	tion	100	6b. Kind of Business	
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Maryland	I be fi	Be	17. Father's Name (First, Middle, Last		1		18. Mother's Name		aiden Sumame)	
Ž	2 should be and Mental Is marked (2	Ralph W. 19a. Informant's Name/Relationship	Hamm		ing Address (Street a	Bessie S		City or Tour State	Zin Code)
Z	trau		Clifford Jones -	**) Powellvi			,	, - ,
Ğ,	s 1 and 2 f Health Itsm 27 I		20a. Method of Disposition	nabbana	20b. Place of Diso		0		Oc. Location - City o	
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			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the	e death. Do not en	ter the mode of dying	, such as cardiac o	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Acute	0/48/019	d Leukin	Mia			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):	neart +	il. The			
8	ă.	76	Sequentially list conditions,	b. Due to for as a c	consequence of):	16414	41/0188			
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	333.13	, on a oquotion of 7.					
Ć.	exection and ital-tra	Exa	that initiated events resulting in death) Last	C. Due to (or as a c	consequence of):					
68760,	icate be executed physician and s the burial-transit	edicai		d						
_	ng ph		IF FEMALE:							
Вох	death certi e ettending id for use a	an/h	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2		☐Ectopic pregnancy			23d. Date of de Month	Day Year
		Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at tin 9☐ Unknown	ne of death 5	Other (specify)			Month	Day Toal
P.0.	that the ed by th detache	Ph)	Part II. Other significent conditions	contributing to death but	not resulting in the	underlying cause give	in in Part I	23e. Did toba	acco use contribute	to the cause of death?
ords,	w requires been sign should be	ted by								robably 41/2Unknown
Vital Records,	The law ate has b page 2 s	Completed						24a. Was an autopsy perform	ed? prior to	utopsy findings available completion of cause of successions 2 No
/ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	
of	S S D	Lo	1 Yes 20 No	Hospital:			4 Nursing Ho		nce 6 Other (Sp	ecify)
on (Jing F After funera	ion:	27. Manner of Death 1 Naturat 5 Pending	28a. Date of Injury (Month, Day)	/ear) 28b. Time (Injury	Work		28d. Describe how	w intury occurred	
Division	Attending r death. sctor: After by the fune	lcat	2 Accident investigation 3 Suicide 6 Could not t	OB Blace of Injury	- At home farm st		fes 2□No	28f Location (Str	eet and Number or F	Rural Route Number
<u>S</u>	tal or A	Certification:	4 Homicide determined	building, etc.	(Specify)	reet, ractory, office		City or Town,		idia / iodio / dilibo/,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one)	hysicien: To the best of miner: On the basis of example and manner state	xamination and/or in	th occurred at the tim nvestigation, in my op	e, date and place, pinion, death occurr	and due to the car ed at the time, da	use(s) and manner a te and place, and du	as stated. se to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1)	29c. License	number	, 29	d. Date signed (Mor	nth, Day, Year)
	X		P	4		700	66198		10 24 6)
	Alex		30. Name and address of person who		th (Item 23a) (Type	Print)	1	4 1 1	0	Sal
100	Sta	io.	31. Date filed (Month, Day, Year)	120, 145 F	s Signature	11 St. Suit	E 4-1.	Jalisbur	TIND &1	801
	ા Registi		OCT 2 3	2007 /	er &	Smart)		,		

07-08397

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

nilip E. Kelly		State of Maryland / De 1- For State	partment of Certificate of			200	7 3563
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	or timodito or		2. Date of Death	1	3. Time of Death
ledical Exami		Philip E. Kelly, Sr.			Month October 28	Day Year , 2007	1317 hrs
		4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or Location of	Death	4c. County of Death	
		Western MD Health System Braddock		Cumberland		Allegany	
Funeral		5. Social Security Number 6. Sex 7. Age (In yr	rs. last birthday)	If Under 1 Year If Under Months Days Hours	24Hrs. 8. Date of Birth Min.	n(MM/DD/YYYY) 9. Birt Foreig	n l
Director	L		84 Yrs.		10/09	/1923 Con	untry) WV
÷	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. 0	City, Town or Location	on			10d. Inside City Limits
ow any		·	•				1 Yes 2 X No
Maryland 28a-f show 1 at once.	흱	WV Mineral	Keyser	10f. Zip Code	110	g. Citizen of What Cour	ntry?
e Mai or 28 Fred a	Director						•
vith th		250 Bobwhite Drive 11. Marital Status 12. Was Decedent Ever i	in U.S. 13. Was	26726 Decedent of Hispanic Origin	n? (Specify Yes or No-	USA 14. Race - Ameri	ican Indian, Black,
eath v item	Funeral	1 Never Married 2 X Married Armed Forces?	If Ye	es, specify Cuban, Mexican, I	Puerto Rican, etc.)	White, etc.	
fter d I", or		1 X Yes 2 N 3 Widowed 4 Divorced If Yes Give Year WW]		Yes 2 X No specify:		Specify: 7	Vhite
ours a atura xamii	d b	15. Decedent's Education (Specify only highest grade completed		's Usual Occupation (Give ki		16b. Kind of Business/	Industry
6 172 h an "n cal E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during me	st of working mo. Do Nor o	35 / 54// 54/		
within jene.	鬞	12	Ma	achinist	Name (First, Middle, M	Railr	oad
filed I Hyge of orf		17. Father's Name (First, Middle, Last)				laiden Somanie)	
212 Ild be Menta mark	e B	William T. Kelly 19a, Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and Numb	ay Bell per or Rural Route Num	ber, City or Town, State	e, Zip Code)
AD 2 shot and and is martic	-	Margaret V. Kelly/Wife	21	50 Bobwhite D	rive Kevse	er. WV 267	26
e, P	ı	20a. Method of Disposition 2	Ob. Place of Disposi crematory or oth	tion (Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 X Cremation 3 Removal from State	•	land Cremato	Oct. 30 ry 2007	Cumberla	nd. MD
altir nit. F portar iny or		4 Donation 5 Other Specify: 21. Signature of Funeral Service Ligensee		ame and Address of Facility		neral Home	,
iii ii ge Ber		Music FARELLA	2016	85 S. Main	Street Ke	eyser, WV	26726
Physician		23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.	eath. Do not enter th	ie mode of dying, such as ca	rdiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a. Hypertensive Athero	sclerotic Cardi	ovascular Disease			Death
жанны		or condition resulting in death) Due to (or as a consequent	ice of):				
	ᡖ	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequen	ice of):				
	Examiner	cause. Enter Underlying Cause					
Inst. of Kuy	ä	events resulting in death) Last Due to (or as a consequent	ice of):				
xecuted n and 1 - transit		dd					
Division of Vital Records, P.O. Box 68760, in the Hospital or Attending Physician: The law requires that the death certificate be executed frin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and hipletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical		progpanav.			23d. Date of deliver	TV
Box 6876 The death certificat The attending physel for use as the	N/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 Live birth		tal death 3 Ectopic	pregnancy		Day Year
th cer trendi	icia	4 Pregnant at time of	of death	ner (Specify)			
BC ne dea	Physician/	9 Olikilowii		and and the anyon sixon in Day	+1 23e Did to	bacco use contribute to	the cause of death?
that the operation of t	by	Part II. Other significant conditions contributing to death but I	not resulting in the t	inderlying cause given in Par			bably 4 V Unknown
S, quires en sig	ted					an I 24b. Were a	utopsy findings available
aw renas be	ed l				autop		completion of cause of
Rec The l	Completed				1 ✓ Yes	2 No 1 Y	es 2 No
cian: certif	Be	25. Was case referred to medical examiner?		26.Place of Death (Desidence of Control	
of Vital Records, P.O. ling Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach	2	1 ✓ Yes 2 No	2 ✔ ER/Outpatient 28b. Time of I		Nursing Home 5 28d, Describe	Residence 6 Othe	er:
rding h.: Afte	io ::	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	200. 11110 017	1 Yes 2		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Sior Attend r death ector: by the	cat	2 Accident Investigation 28e, Place of Injury -	At home, farm, stree	et, factory, office building, etc	28f. Location (Street and Number or R	tural Route Number, City
Divisi pital or Att ours after d neral Direct	Certification:	3 Suicide 6 Could not be determined (Specify)			or Town, S	State)	
Hospi 4 hou Funer ely fil		29a. Certifier 1 Certifying Physician: To the best of my know	wledge, death occur	red at the time, date and pla	ce, and due to the caus	se(s) and manner as sta	ited.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examinating and manner stated.	ion and/or investiga	tion, in my opinion, death occ	curred at the time, date	and place, and due to t	he cause(s)
To With	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mi	onth, Day, Year)
		web2_		O.C.M.E.		October 29, 200	07
		30. Name and address of person who completed cause of death					
10		Ana Rubio MD. Assistant Medical Examine		treet, Baltimore, MD	21201		
	tate	6 t 6 t 1 1 C 71 11 1 3 T 1 1 1	gnature	EL P			
Regis	trar	NOV 0 6 2007 Season.	5				

ORIGINAL

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State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Annabelle Louise Kistner 9 2007 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Future Care - Cherry Wood Reisterstown Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 1 ☐ M 2 💢 F 217-12-0266 86 Director 8/02/1921 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No Maryland Carroll Director Hampstead 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4355 Sycamore Drive 21074 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 δ 3 X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. 11 Homemaker Residence is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Still ပ္ Cora Yinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i Robin L. Weisse - Attorney 212 Pennsylvania Avenue Westminster, Maryland 21157 20b. Place of Disposition (Name of cemetery crematory or other n 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Pine Grove Cemetery 10/25/2007 Parkton, Maryland 22. Name and Address of Facility Eline Funeral Home 934 South 21. Signature of Funeral Service Licenses M01490 Main Street Hampstead Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between nset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erlinom /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exam physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at lime of death 5 Other (specify) the 9□Unknown 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy page this certificate 2 3 No or Attending Physician: rector, To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ğ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 ☐ Accident Funeral Director: tely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 P the 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) Ms

State Registrar 30. Name and ad

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

person who completed cause of death (Item 23a) (Type, Print)

200

Physici /Medi Examir

Funeral Director

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1 - For State Registrar	ate of Maryland /		cate of De			leg. No.	UI	35635
Decedent's Name (First, Middle, Last)		-			2. Date of Dea		Vaar	3. Time of Death
Jean Keenan	•				Month 16	Day	2007	3:30 PM
4a. Facility Name (If not institution, give street		4b.	City, Town, or Lo	ocation of Death			nty of Death	1
Coastal Hospice at th			SOJIS	hury		1	Nico	MICO
5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If L		f Under 24 Hrs.	8. Date of Birtl	h	_	place (State or Foreign
166-05-0853 ¹□M	2 ∏ F 93	Yrs. Mo	nths Days	Hours Min.	(Month, Day 8/15/19	/, Year) Al∕I		nsylvania
Usual Residence of Decedent					0/13/13	/ 1-1	1 0111	IDY I VOITE
10a. State 10b. County	10c. City, T	own or Location	n					10d. Inside City Limits
Maryland Wicomico	Sal	isbury						1 ☐ Yes 2 XN
10e. Street and Number			of, Zip Code			10g. Citizen	of What Cou	untry?
611 Tressler Dr.			21801			USA	A	
	/as Decedent Ever in U.S.	13 Was I		anic Origin? (Sc	ecify Yes or No-	14. [Race - Amer	ican Indian,
A A	med Forces? ☐ Yes 2 ☑ No	If Yes	Decedent of Hisp. , specify Cuban,	Mexican, Puerto	Rican, etc.)		Black, White	e, etc.
lf lf	Yes, Give ear or Dates:	1 🗆 Y	es 2X No	Specify:		Spe	ecify: wh	ite
15. Decedent's Education	170	6a Decedent's	Usual Occupation	20	Ī	16b. Kind o	f Business/I	ndustry
(Specify only highest grade con	npleted)	(Give kind	of work done duri OT use retired)	ring most of work	king			,
	ollege (1-4or 5+)	waitres				food	serv	ri co
17. Father's Name (First, Middle, Last)		waltres		8. Mother's Nam	e (First, Middle,			106
James Joseph Connors	•			Mary Ce	ecelia C	alvev		
19a. Informant's Name/Relationship (Type, F	Print)		dress (Street and	d Number or Ru	ral Route Numbe	r, City or To		ip Code)
Richard C. Keenan/so			ogwood I					
20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Remove	come	e of Disposition etery, cremator	i (Name of y or other place)	İ	Date	20c. Locati	on - City or 1	Iown, State
'4 □Donation 5 □Other (Specify)		sbury C	rematory	10/2	2/07	Salis	bury,	MD
23-Signature of Funeral Service Licensee	MAD CESP	² Hol 501	ne and Address IOWAY Fr Snow H.	of Facility Uneral H ill Rd.	Home Pro	fessionry, i	onal A	ssociation
23a. Part 1. Enter the dil ease, or complicato	2000	1						Approximate
shock, or heart failure. List only one ca	use on each line.							Interval Between Onset and Death
disease or condition resulting in death) a.	DEMBN							
Toolstang an doubly	Due to (or as a consequen		- 1.6	0 2 - 0	1 -0 7			
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if any, leading to immediate cause. Enter Underlying	Due to (or as a consequen	ice or).						
Cause (Disease or injury that initiated events c	Due to (or as a consequen	an of						
	Due to (or as a consequen	100 017.						
d								
IF FEMALE:								
in the past 12 months?	yes, outcome of pregnancy Live birth 2 Petal de	ath 3 ☐Ecto	pic pregnancy			23d.	Date of deli Month	very Day Year
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9 □ Unknov(n					00.001			
Part II. Other significant conditions contribu	ting to death but not resultir	ng in the underl	ying cause given	in Part I.			9	the cause of death?
					10	Yes 2 N	lo 3 Pro	obably 4 Unknow
					24a. Was		4b. Were au	topsy findings available
					autor perfo	rmed?	death?	
25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	(1 🗀 162	7110
examiner? Hospi	tal:		Other				Ost as (C- a)	
The state of the s	4	VOutpatient 3 3b. Time of	L DOA	4 Ivuising n	ome 5 Resident			ciry)
Natural 5 Pending	(Month, Day Year)	Injury	28c. Injury a Work? 4 1 □ Ye	s 2 □No	200. 0000.20	ion injury or		
2 Accident investigation 3 Suicide 6 Could not be	Do Diago of Inius Atheres				28f Location /	Street and Al	umber or Pr	ıral Route Number,
4 Homicide determined	Be. Place of Injury - At home building, etc. (Specify)	e, ratini, Street, i	actory, office		City or To		amour or Au	
					<u> </u>			
(Check only (2 Medical Examiner:	n: To the best of my knowle On the basis of examination and manner stated.	edge, death occ n and/or investi	curred at the time, gation, in my opin	, date and place nion, death occu	, and due to the rred at the time,	cause(s) and date and pla	d manner as ice, and due	stated. to the cause(s)
29b. Signature and this of certifier	-		29c. License r	number		29d. Date s	igned (Monti	h, Day, Year)
			20	0594	10	1-	-10	-00
180			1				-19	
30. Name and address of person who comple	ated cause of death (Item 23) ASTAL Ho 32. Registrar's Signatur	3a) (Type, Print	Da 1.	. (0.		1	4 .	
CHUITIN WARLS CE	ASTAL TTO.	SPICE	POBO	C 173.	SAL	15034	12	ms 2180
31. Date filed (Month, Day, Year)	32. Registrar's Signatur	& Anas	the s				(

					artment of Health and	Mental Hygie	ene	
_			1 - State Registrar	Ce	rtificate of Death		. No. 2007	35636
2	Physici		1. Decedent's Name (First, Middle, Last) Mary Theresa Lane			2. Date of Death Month October 2	Day Year 21. 2007	3. Time of Death 8:25 P M
TO A	/Medi Examir		4a. Facility Name (If not institution, give street and nu	imber)	4b. City, Town, or Location of Deat		4c. County of Deat	
			1124 Cresthaven Drive		Silver Spring		Montgome	
l	Funeral Director		5. Social Security Number 214-90-9928 6. Sex 1 □ M 2 耳	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Y	9. Birtl Co. 1965 Mar	nplace (State or Foreign untry) yland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Maryl -f sho	ţō	Maryland Montgomery	Silver Sp				1 □Yes 2X No
	th with the 23a or 28a st be noti	al Direc	10e. Street and Number 1124 Cresthaven Drive	L	10f. Zip Code 20903		. Citizen of What Co United Sta	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or Items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or Items 23a or 28a-f show amportant in	by Funeral Director	Armed F	orces? 2 2 No ive	Uas Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: WI	
5-0	72 hc 'natul	eted	15. Decedent's Education (Specify only highest grade completed,	16a. Dece	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking L	6b. Kind of Business/l	
121	within ene. than "	Completed		1-40r 5+1	ofessor		nne Arunde ommunity (
d 2	Hygie other ent, th	Be Co	17. Father's Name (First, Middle, Last)		Υ	me (First, Middle, Ma		3011080
/lan	uld be Vental rked ric ev	To B	Daniel Joseph Lane, Sr.		Dorothy	S. Roger	S	
Maryland	2 sho and h is ma rauma	. 8	19a. Informant's Name/Relationship (Type. Print)	1	ng Address (Street and Number or R			•
	1 and Health em 27 ther to		David H. Schwartz (Husba 20a. Method of Disposition	20b. Place of Dispo	Cresthaven Drive		pring, MD	
Baltimore	Pages ment of tant: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Security)	State Gate Cem	of Heaven Octo	ober 26, 2007 Si	lver Spri	ng, MD
Ball	Departiment Departiment any in once,		21. Signature of Funeral Service Licensee		2. Name and Address of Facility Doler Park Drive,		-	
	Physician /Medical		resulting in de th)	caused the death. Do not enteach line. astatic Breas (or as a consequence of):		c or respiratory arres	t,	Approximate Interval Between Onset and Death 10½ years
	Examiner		Pri	or Stage II B	reast Cancer			12 years
	Po #s	iner	if any, leading to immediate Due to	(or as a consequence of):				<u> </u>
	and and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	(or as a consequence of):				
68760,	icate be executed physician and the burial-transit	dical E	d	(
	# D &	ledic	J		***************************************			
P.O. Box	that the death certifined by the attending I	Physician/Me	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	ivery Day Year
	res that signed b be deta	by Pr	Part II. Other significant conditions contributing to o	leath but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ord	w require been sig should b	ted k				1 ☐ Yes	2⊠ No 3□ Pr	obably 4 Unknown
I Records,	The la ate has page 2	Completed				24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of 2 No
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?			ath (Check only one)		
or	is dir	은	1 ☐ Yes 2 ₹ No Hospital: 1 ☐ 27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatier of Injury 28b. Time o			ce 6 □Other (Spec	cify)
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	To the Hospital or Attend within 24 hours after death. To the Funeral Director: / completely filled in by the fi	Medical	(Check only 2 Medical Examiner: On the I	e best of my knowledge, deat pasis of examination and/or in oner stated.	h occurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To the Complex of the	ž	29b. Signature and title of certifier		29c. License number	290	I. Date signed (Monti	h, Day, Year)
	18		My Chymn Hr	who	MT D37236	0c	tober 22,	2007
			30. Name and address ferson who completed cau Carolyn B. Hendricks, M.	D., 6410 Rock		, Bethesd	a, MD 208	17
	Sta Registr		OOT OO OO	Spistrar's Signature	best			
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Opertificate of Death

0		-	2	•
J	J	0	J	

3. Time of Death

10d. Inside City Limits

20640 Approximate Interval Between Onset and Death

Day

Year

1 Yes 2 No

9:15 PM

1. Decedent's Name (First, Middle, Last) OCTOBER 21, 2007 **Physician** ANTONIO MACIO LEWIS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES FORT WASHINGTON FORT WASHINGTON HEALTH & REHABILITATION 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 XM 2 ☐ F 96 FLORIDA NOV. 11, 1910 266-12-2118 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at Director ACCOKEEK MD PRINCE GEORGES 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or UNITED STATES 20607 18428 SHANNA DRIVE r than "natural", or Items 23s the Medical Examiner must Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XNo altimore, Maryland 21215-0036 Specify: BLACK þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nany Injury or other traumatic event. the Ment College (1-4or 5+) Elementary/Secondary (0-12) RESTAURANT ENTREPRENEUR 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY DRAYTON LEWIS ISSAC LEWIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 18428 SHANNA DRIVE, ACCOKEEK, MARYLAND PATTY DORSEY/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 10/27/2007 JACKSONVILLE, FLORIDA PALM SPRINGS CEMETERY ica Address of Facility P.A. LIVINGSTON ROAD, INDIAN HEAD, MD LYDIA C. THORNTON JOHNSON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) andisvarila niscase **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the tending por use as 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?
Yes 2 1 No 1☐ Yes 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To

Hospital or Attending Physician: The law requires that the death cartificate be executed after death Director: n 24 hours aft le Funeral Di eletely filled in within 24 ho

To the Fund

completely for

K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

27. Manner of Death

1 Natura!

2 Accident

3 ☐ Suicide

4 Homicide

29c. License number 045365

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

2007

28a. Date of Injury (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mich AEL Sidanon, M.D. 11701 living to no #101, fortum by a month of the many of the month of the mon 32. Resistrar's Signature 31. Date filed (Month, OCT 2 3

Medical

Division or Vital Records, P.O. Box 68760,	Baltimore, Maryland 21215-0036
afor Jeah	permit. Pages 1 and 2 should be filled within 72 hours after death with persent of Health and Mental Horisone.
I Director: After this certificate has been signed by the attending physician and Important: If item 27 is marked other than "natural", or items 23a o	Important: If item 27 is marked other than "natural", or items 23a

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Physicia											3. Time of Death 10:24 P M
/Medical Examiner		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. City								ounty of Death	l
Funeral Director		5. Social Security Number 231–50–5822	6. Sex 1 M 2	ge (In yrs. last birth	B.A	Under 1 Year Ionths Days	Hours Min.	8. Date of Bir (Month, Da Apr. 14	th ay, Year) , 194	9. Birth	place (State or Foreign intry) Sinia
w		Usual Residence of Decedent 10a. State 10b. County	v	10c. City, Town	or Location	on				1	10d. Inside City Limits
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	rot	Ohio Trum		Cortlar							1 □Yes 2 No
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and 2 sh ealth and n 27 is m		Joy E. Lepola-		ghter 12	218 W	Voodland	Court 1	Hampste	ad, Ma	aryland	21074
Pages 1 ment of H ant: If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 4 ☐ Donation 5 ☐ Other (-			l Cr	on (Name of ory or other place emation	10/2		Hamps		Fown, State Maryland
permit. Depart Import any inj		21. Signature of Funeral Service	e Licensel	M01072	22. Na 934	ame and Addres	s of Facility El Main Stre	ine Fur et Har	neral npstea	Home nd, Mar	yland 21074
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uires that i signed by Id be detai		Part II. Other significant condit	tions contributing to death i	but not resulting in	the unde	rlying cause give	en in Part I.		tobacco use		the cause of death?
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To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	ledical C	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									stated. to the cause(s)
To th Within To th	Me	29b. Signature and title of certifier 29c. License number 29d. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 644 Cowww, 44 6579 N. Compact St. Stringers 31. Date filed (Month, Day, Year) 32. Registrar's Signature 0CT 2 3 2007 Market St. Analy						29d. Date	29d. Date signed (Month, Day, Year)		
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De la companya de la		30. Name and address of perso	n who completed cause of W MP 656	death (Item 23a) (1	Type, Prin	nt)	Str	MAGN	5,7	0 2/2	-64
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Division To the Hospital or Attend within 24 hours after death. To the Finneral Director: completely filled in by the I	ပြ		e	Physician: To the	cify) Fnd:			at the time	e, date and pla					
the H the Fi the Fi	Medical	(Check only one) 2	✓ Medical E	xaminer: On the ba	asis of examina	ation and/	or investigation,	in my opir	nion, death oc	curred at the time	date an	d place, and due	e to the cause(s)	
To Your To Com	Med	29b. Signature	and title of cer		ner stated.			29c.Lice	ense number				(Month, Day, Year)	
2 41		C	in h	w. n	S			0.	C.M.E.		1	October 11,	2007	
UQU		30. Name and a	ddress of per	son who completed	cause of deat	h (Item 23	a)				1.			
V		Ling Li, N	1D Assi	stant Medical E	Examiner	111 P	enn Street, E	Baltimo	re, MD 212	201				_
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DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Alice M. Montague \mathbf{P}^{M} October 16. 2007 7:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Laurel Health & Rehab. Prince George's Laurel If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛛 F 87 579-22-4060 Yrs Director 4-22-1920 BowlingGreen, WV Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits items 23a or 28a-f show Examiner must be notified at Director 1 XYes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 5202 11th Street NE United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Mariana. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify: 3 Widowed 4 □ Divorced Specify: Black 9 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service Worker George Washington Univ. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Folley Fox Rachel Christopher 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwina Montague (Daughter) 1519 Pennsylvania Ave SE Washington, DC 20003 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 10/20/2007 Brentwood, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Brentwood, MD 20722 Bladensburg Road Rectuel Chary 23a. Part1. Enter the di ease, il complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fa ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer Dementia /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Sacral Decubitus and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☑ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Cornary artery disease Completed page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division or Vital 2**∏** No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after fo the . within 24 hour. *he Funeral D' 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of sxamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed Month, Day Year) 30. Name and dress of person we o complete cause of death (Item 23a) (Type, Print) 13635 Baltimore Ave Laurel, MD 20702 Darryl Hill, MD32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Yea

OCT 2 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 ema Nysa /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number 6. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex Days **Funeral** 1 M 2 F 8 Yrs. 225-70-4501 Usual Residence of Decedent 5 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Funeral Director MD. 10g. Citizen of What Country? 10e. Street and Number 20781 4410 12. Was Decedent Ever in U.S. Armed Forces? American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. orces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Blac à 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOA Specialist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ly soes Boyd 1 helma ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Md know 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10-22-07 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Facility 22. Name and Address 6 St. Alexandria Va. 22314 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 2 ER/Outpatient 3 DOA 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 28d. Describe how injury occurred 28b. Time of

The law requires that the death certificate be executed burial-tra Division or Vital Records, P.O. Box 68760, cate has b certificate Hospital or Attending Physician: this After t To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A

Baltimore, Maryland 21215-0036

27. Manner of Death 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 ☐ Homicide

1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

MIS

10060417 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

shah

31. Date filed (Month, Day, Year)

32. Registrar's Sig

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20^{Day} Month 2007 **Physician** Oct. 10:20p Jacqueline Lee McCullough /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 🗓 F 54 11/09/1952 Virginia Director 225-74-3781 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☑ Yes 2 ☐ No Director Maryland | Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20782 USA 3214 Toledo Place, #204 Completed by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle E. Carter Unknown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3214 Toledo Place, #204, Hyattsville, MD 20782 George J. McCullough/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 10/23/2007 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 20722 3401 Bladensburg Rd., Brentwood, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a BUATERAL PNEUMONIA. **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine HYPOTENSION certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, ARTHRITIS RHEUMATOID Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a ld be detached for P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by HYPONATROMIA 1 Yes 2 No 3 Probably 4 Unknown Completed HYPOGLYCEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has performed? 1☐ Yes 2 🖸 No Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-59284. 10/21/2007

State

31. Date filed (Month, Day, Year) OCT 2 3 2007

SUAMIM.

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHUD SHAWM, HI) WASHINGTON ADVENTIST HOSP, TANCORMA PARK MD-20912

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked of other than "natural", or items 28a or 28a-f show any latest than the resulted to the standard or one who Marked Examines he notified to	any might be under traumant event, the medical charming most be normal
,	Physici /Medio Examir	a ca 16
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in but the funeral director name?	÷

Funeral Director

eath with the Maryland

		For State Registrar	State of Maryland		rtificate of L		ental Hygie Reg	No.2007	35644			
Physicia /Medic		Decedent's Name (First, Middle, Sara McCain N	Last) McCollum				2. Date of Death Month October	Day Year 20, 2007	3. Time of Death 11:20 P M			
Examin		4a. Facility Name (If not institution,	give street and number)			Location of Death		4c. County of Dea	th			
		Holy Cross Hosp 5. Social Security Number	oital 6. Sex 7. Age (In yrs. k	ast birthdav)	Silver S		8. Date of Birth		gomery thplace (State or Foreign			
Funeral Director		243-78-9955 Usual Residence of Decedent	1□M 2ÅF 88	Yrs.	Months Days		Jan. 5, I	919 Noi	Cth Carolina			
at		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits			
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3a or 28 st be no	al Director	10e. Street and Number 4004 Evangelir	ne Terrace		10f. Zip Code 208	332	10g	. Citizen of What Co USA	ountry?			
Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Spe in, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: WI				
n "natur Medical B	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed)	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired,	ation during most of worki)	ng 16	b. Kind of Business	/Industry			
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fental Hy rked oth tic event	To Be (17. Father's Name (First, Middle, La Paul P. McCair	iden Surname)									
and N Is mai		19a. Informant's Name/Relationshi	p (Type. Print)	19b. Maili	ng Address (Street a	and Number or Rura	il Route Number, C	City or Town, State,	Zip Code)			
m 27		Sara M. Thiesme			Evangelin							
ant: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	3 Elnellioval ilolli State		osition (Name of matory or other place Memorial		Oct. 27	c. Location - City or Reidsvil	·			
Departr Imports any Inju once,		21. Signature Funeral Service Licensee Francis Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901										
200		23a. Part1. Enter the disease, or c shock, or heart failure. List o	complications that caused the death						Approximate Interval Between			
ysician Medical		Immediate Cause (Final disease or condition resulting in death) a. Right Lower Lobe Pneumonia Due to (or as a consequence of): Cnset and Death Days										
aminer	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Severe Dementia Due to (or as a consequence of): years Due to (or as a consequence of):										
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	nysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23d. Date of de Month	23d. Date of delivery Month Day Year								
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this cal dire	ဥ	1 ☐ Yes 2X No 27. Manner of Death	Hospital: 12 Inpatient 2 E	ER/Outpatie		4 LI Nursing Ho		ce 6 □Other (Spe	ecify)			
th. : After s funer	cation:	1X Natural 5 Pending 2 Accident investiga	(Month, Day Year)	Injury	Work	Yes 2 □No	28d. Describe how	injury occurred				
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24 hours e Funeral etely filled	Medical Co	29a. Certifier (Check only one) 1. Certifying 2 Medical E	Physician: To the best of my know xaminer: On the basis of examinat and manner stated.	wledge, deat tion and/or in	th occurred at the time	ime, date and place, and due to the cause(s) and manner as stated. opinion, death occurred at the time, date and place, and due to the cause(s)						
To th	Me	29b. Signature and title of certifier			29c. License	number	290	. Date signed (Mon	th, Day, Year)			
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5		AHMEO NAWA	who completed cause of death (Item	819	Gaithe	ersburg	7 mo	20883				
Sta Registr	_	31. Date filed (Mon(1) Pay Year)	32. Fedistrar's Signat	ture.	berte		,					

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 35645 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MANNICK DONALD 2317 M OCTOBER 23 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. Counfy of Death **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 11XM 2□ F 218-78-5016 Director July 1, 1958 Maryland 49 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐Yes 2 ☑ No Director Maryland | Washington Hagerstown nd 2 should be filed within 72 hours after death with the Ith and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-traumatic event, the Medical Examiner must he north 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 Stanford Road 21742 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) electrician electrical contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental important: If Item 27 is many injury or other Be Donald Michael Mannick, Sr. ဥ Carol Ann Hileman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Stanford Road, Hagerstown, Maryland 21742 Vanessa A. Mannick - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 MacCremation 3 ☐ Removal from State Hagerstown Crematory: 10/25/07 4 Donation 5 Dother (Specify) Hagerstown, Maryland 21. Signature of Furieral Service Licenses 2). Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 innix 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT **Physician** I WEEK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine MYELOGENOUS LEVKEMIA Vears Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and burial-tran Due to (or as a consequence of) nding physician use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign I be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After thi 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 M Natural ours after death.

neral Director; A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064512 MEDICAL DOCTOR OKTOBER, 23, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anH-10 NEIL AGGARWAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND, 21287 31. Date filed (Month, Day, Year) 2007 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35646 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9:00 } Betty Arline Millward 2007 Ctober 21 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hagerstown Washington County Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 82 August 5 1925 Maryland 219-20-1279 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🎾 No Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21740 1183 Luther Drive 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White 3 XWidowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commission on Aging Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tracy Bolton Calhoun Elizabeth R. Riedel Calhoun 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2890 Oak Hill Road Waynesboro Pennsylvania 17268 William Frank Alder - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 10-25-2007 | Hagerstown Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee

Physician /Medical

Physician

/Medical

Examiner

10a State

Director

Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene. Important: If teem 27 is anarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner

Examiner burial-trar ed by the attending physician detached for use as the buria Physician/Medical signed by t Be Completed by cate has been sig Medical Certification: To within 2.

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Kaitlin Zalt	aron	1331 Eas	tern Blvd.	N. Hagers	town Maryl	and 21742
23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	ations that caused the death. Do not cause on each line.	enter the mode of	dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of)		cardio	vesula	i denoi	Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence on	•				
that initiated events c. resulting in death) Last	Due to (or as a consequence of)	:				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregr 5 ☐ Other (specif			23d. Date of deliver Month	ry Day Year
Part II. Other significant conditions conti	ributing to death but not resulting in the	ne underlying caus	e given in Part I.		cco use contribute to th	N
				24a. Was an autopsy performe 1 Yes 2	prior to con death?	psy findings available inpletion of cause of 2 No
25. Was case referred to medical examiner?				th (Check only one)		
T Yes ZVINO	ospital: Inpatient 2 ER/Outp		Other: 4 ☐ Nursing H		e 6 □Other (Specify	2
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tir Inju	ary M	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, or	ffice	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	cian: To the best of my knowledge, er: On the basis of examination and/ and manner stated.					
29b. Signature and title of certifier		29c. L	cense number		. Date signed (Month,	Day, Year)
Ilaugar of	nog	D	28365		10-22-27	
30. Name and address of person who con	npleted duse of death (Item 23a) (T		iels Stre	ur Hou	gestein	M D21740

State Registrar DSHAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day $\underline{A}^{\mathsf{M}}$ 21, Woodrow McIlwaine 2007 12:12 October 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) Months 1 XIM 2 □ F Nov. 5, 1937 230-40-3599 69 South Carolina Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Virginia | Fairfax Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7914 San Leandro Place 22309 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 years Federal Government Employee Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ferry McIlwaine Juanita Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11100 Inverrary Court Bowie, Maryland 20721

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Physician /Medical

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

19a. Informant's Name/Relationship (Type. Print)

Marcus M. McIlwaine, Sr. - Son

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TERRY JODRIE, MD

31. Date filed (Month, Day, Year)

DCT 2 4 2007

Funeral

Director

Examiner

certificate be executed

Division or Vital Records, P.O. Box 68760,

burial-tra as the use ō signed by the a d be detached for To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director:
completely filled in by the f

	20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State	cemetery, crematory	or other place)	Date	20c. Location - City or	
	4 □ Donation 5 □ Other (Specify) 21. Sign, ture of Funeral Servic, Licensee	N AIR/A	e and Address of Facility S Benning Road	tewart		, Inc.
	resulting in death)	the death. Do not enter the e. EMOCARA a consequence of):		c or respiratory		Approximate Interval Between Onset and Death
Be Completed by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):				
hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐ Ectop	ic pregnancy r (specify)		23d. Date of del Month	ivery Day Year
ed by P	Part II. Other significant conditions contributing to death bu	t not resulting in the underlying	ng cause given in Part I.		tobacco use contribute to]Yes 2□No 3□Pr	
Complet					opsy prior to death?	itopsy findings available completion of cause of 2 ☐ No
Be	25. Was case referred to medical examiner?		26. Place of Dea			
2	1 ☐Yes 2 ☐ No Hospital: 1 ☐ Inpatie		DOA Other: 4 Nursing H	lome 5 ☐ Re	sidence 6 Other (Spe	cify)
ation:	27. Manney of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation (Month, Day		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	e how injury occurred	
Sertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injubility, etc.	ry - At home, farm, street, fac :. (Specify)	ctory, office		(Street and Number or Ru own, State)	ıral Route Number,
Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner sta	examination and/or investiga	rred at the time, date and place ation, in my opinion, death occi	e, and due to thurred at the time	e cause(s) and manner as e, date and place, and due	s stated. to the cause(s)
Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mont	h, Day, Year)
	29b. Signature and title of certifier		D40324		OCTOBER 2	21,2007

State

Registrar

503 URRATTS ROAD, CLINTON, MAPYLAND

20735

07-08256 Consetta Martin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 35648 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day October 23, 2007 1641 hrs Medical Examiner CONSETTA MARTIN 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Prince George's Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign WASHINGTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** Min. Months Days Hours Director MARCH 31 1974 Country) 228-27-3423 м 2X F 33 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No PRINCE GEORGE'S FT. WASHINGTON MD notified at once, 10g. Citizen of What Country? 10e, Street and Numbe 10f. Zip Code U.S.A. 20744 12604 ABBOTTSFORD CIRCLE 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be a Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2X No Yes Widowed If Yes, Give Year Yes 2 X No specify: Specify: BLACK Divorced ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 hours Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 PRIVATE SR. POST CLOSER 12th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Sumame) NATHANIEL H. MARTIN SR. GAYLA BRYANT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12604 ABBOTTSFORD CIRCLE FT. WASHINGTON, MD 20744 GAYLA PARROTTE/MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place 1 X Burial 2 Cremation 3 Removal from State HARMONY CEMETERY 10-29-2007 LANDOVER, MARYLAND Donation 5 Other Specify: 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Pulmonary thromboemboli Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Deep leg vein thrombosis Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician or use as the burial AMENDED a-b, PII,27,perME,g873, 11/8/07 TT Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 V Unknown 9 Unknown by the z Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ğ Division of Vital Records. P. Dehydration Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? ✓ Yes 2 death? certificate 1 🗸 Yes 2 No No To the Hospital or Attending Physician: 'within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other; Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 this Residence 6 1 🗸 Yes 2 After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 Pending To the Funeral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 24, 2007 rson who completed cause of death (Item 23a) OCM Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Da 32. Registrar's Sign ture

Registrar

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08407 State of Maryland / Department of Health and Mental Hygiene Rachel Francis Magana Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Month Day October 29, 2007 Physician/ 0059 hrs Rachel Francis Magana Medical Examiner 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Cecil Elkton Union Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Min Hours Months Days Country) DE 9/13/1960 Director 222-52-4019 М 2 x F 47 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 10a. State 1 Yes 2 x No or items 23a or 28a-f show must be notified at once. MD Œci1 Elktan Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21921 U.S.A. 367 Fletchwood Rd. Apt. 31A 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 X Marrie Yes 2 X No Specify: White Yes 2 X No specify: Yes, Give Year 3 Widowed Divorced "nutural", Exaniner ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 If item 27 is marked other than the traumatic eveut, the Medical Baltimore, MD 21215-0036 Household Housewife Unknown Unknown of Health and Mental Hygiene 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Be Uhknown (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 367 Fletchwood Rd. Apt. 31A Elkton, MD Thomas M. Collins/Husband 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 11/03/2007 West Chester, PA R.A. Ferris Inc. Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of F et S pemit. Service Licensee Andrew G. Gee Funeral Home 259 E. Main ST., Elkton, MD 21921 Approximate Interval r Ve disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. Let only one cause on each line. Death 'Medical a. Methadone intoxication Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED lending physician use as the burial perME.g873 11/9/07 TT 28a-f P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Dav Year Month 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy signed by the attending past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown g 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 ✔ Unknown þ Completed 24b. Were autopsy findings available Records, 24a Was an has been a prior to completion of cause of autopsy performed? death? ✓ Yes 2 ~ Yes 2 page certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Hospital or Attending Physician: Be Other₄ Hospital: examiner? Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this ဥ 1 VYes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Yes 2 X No 1 Natural unk FNd 10/28/2007 Fnd 12:21 and Pending within 24 hours after death. To the Funeral Director: completely filled in by the Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 367 Fletchwood Wood Rd. #31A Elkton, Suicide other-scene (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 31. Date filed (Month, State 6 Registrar

30. Name and address of person who completed cause of death (Item 23a)

DOME

29d. Date signed (Month, Day, Year)

October 29, 2007

29c. License number

O.C.M.E.

29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

20

State

Box 68760.

P.O.

Vital

ORIGINAL

5625 Allentown Rd.,

Camp Springs, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Fatima Hussein, MD

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 35651 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 19, 4:35 P.M 2007 Pari Nawab October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery <u>Bethesda</u> 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number **Funeral** Months 1 ☐ M 2 🛛 F Director 90 1917 Iran May 12, 579-78-1376 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medi al Examiner must be notified at or other traumatic and provided the saminer must be notified at or other traumatic event, the Medi al Examiner must be notified at or other traumatic event, the Medi al Examiner must be notified at or other traumatic event, the Medi al Examiner must be notified at or other traumatic event, the Medi al Examiner must be notified at other traumatic event, the Medi al Examiner must be notified at or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 21 No Directo Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 10216 Rockville Pike, # 302 20852 United States Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Farzanegan zarin Broumand 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10700 Stapleford Hall Drive, Potomac, MD 20854 Esfand Nawab/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 □Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) King David Mem. Park 10/22/2007Falls Church, VA. ture of Fun all ervice Lens 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a End Stage Dementia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🛣 No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Anemia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1∐ Yes 2⊠ No I or Attending Physician; after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: မှ 1 K Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 5 Pending investigation 1 Natural To the Hospital or Attendin within 24 hours after death.

To the Funeral Director A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 66066 30. Name and address of person who cometed cause of death (Item 23a) (Type, Print) Andrew Wong, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month Year) gistrar's Signature State Registrar

Deto BER 19,200

NAWAB, PAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** GERTAUDE 1:12 PM 21 /Medical 2000 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner JNION MEMCRAI Social Security Number 6. Sex Dital MITIMORE 8. Date of Birth (Month, Day, Year) n vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 199-22-5585 Months Days Hours 1 M 2 M Director MID Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director BALTIMOTE CITU SALTIMORE CITY 10f. Zip Code 10e. Street and Number 10q. Citizen of What Country? n 1206 SHAM ROCK USA 4237 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: RLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) MEDICAL MURSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEAN DER NUTTER ANNA WHITE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3506 PARKSIDE DR BALTIMORE, MD 21214 VESHEARA METTS dughTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10-29-07 BIYALVE, MD ELSEY CEMETER 22. Name and Address of Faci 21. Signature of Funeral Service Licensee WICH HOME PO BOX GI Part1. The tilt dis ase, or complications that caused the death. Do not enter the mode of dying, si ch as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** taxwords vanion Sequentially list conditions, if arry, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed errung physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached the 9☐Unknown 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 No 3 Probably 4 2 Probably 4 2 Probably 4 2 Probably 4 2 Probably 4 2 Probably 4 2 Probably 10 Prob Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Impatient 2 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 🗌 Yes 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memoral Gospful Mark Gart Mon

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

KWANE SAHA OSAFO Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-07895 State of Maryland / Department of Health and Mental Hygiene UNK UNK Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 10, 2007 0645 hrs **Medical Examiner** SAKA OSAFO KWAME 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 3400 Winterbourne Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or July Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Country) Ghana Director June 5, 1986 21 Yrs. 053-90-1771 1 X M 2 F Usual Residence of Deceden 10d. Inside City Limits Oc. City, Town or Location 10a. State 10b. County 1 Yes 2 X No 28a-f show Baltimore Maryland Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mertal Hygiene than "natural", or items 23a or 28a-f sho
injury or other traumatic vent, the Medical Examiner must be notified at once Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 Ghana 4031 Greenmont Avenue 14, Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No Specify: Black Yes 2 X No specify. Yes, Give Yea Widowed 4 Divorced <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Home -Dietary Assistant Food Services 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charlotte Graves Elliott Victor O. Osafo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 20720 12007 Manchester Way, Bowie, Victor O. Osafo/Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/27/2007 Silver Spring, MD Gate of Heaven Ceme. Donation 5 Other Specify: 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, 21. Signature of Funeral Servi a Licens e 11800 New Hampshire Ave, Silver Spring, MD20904 Approximate Interval disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the Physician Between Onset and one cause on each line Death Madica a. Gunshot wounds (two) of head and neck Imm at ate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED attending physician for use as the burial -#8525NF, 11/1/07, BMW, McCo The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✔ No 3 Probably 4 Unknown \$ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 1 🗸 ✓ Yes 2 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 27. Manner of Death Certification: Subject shot FOUND: Natural Yes 2 No Pending 0640 hrs Oct 10, 2007 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 3400 Winterbourne, Baltimore, MD Suicide determined (Specify) Local Street 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001 OCME 2006 Ana Rubio MD. Assis

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

gistrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

October 10, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month **Physician** Belinda Sue O'Callaghan 20, 2007 12:35 p.^M Oct. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5317 Upshur Street **Bladensburg** Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🖾 F Director 220-54-2461 55 Jan. 16, 1952 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 28a-f show 1x Yes 2 No Maryland Prince George's Bladensburg Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5317 Upshur Street 20710 USA Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status within 72 hours after 1 ☐ Yes 2 🔼 No If Yes, Give 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White ρ If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than. Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 10 <u>Assistant</u> is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Pasquale Delfino Betty Hurd 2 or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum Rebecca Ann Crook - Friend/POA 12003 Tawanda Lane, Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 10/24/07 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Livenses 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 236. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Arterioscleratic Hypertensive Heart Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be execute burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending physic for use as the b asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 ☐ Unknown ģ page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examined? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 ☐ Homicide Hospital within 24 hours a

To the Funeral
completely filled t 🗌 Ceptifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)

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29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2007 35656 State of Maryland / Department of Health and Mental Hygiene

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Physicia		legistrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death Month	DayYear	3. Time of Death 1256 hrs
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nore, MD 2 ages 1 and 2 shou nt of Health and N nt: If item 27 is n other traumatic	- 8	Randall L. Reynolds/Father 3651 Brook Drive 20a. Method of Disposition (Name of cemetery,	White Date	Plains M 20c. Location - City	D 20695 or Town, State
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Baltimore, permit. Pages 1 at Department of He. Important: If ite injury or other tr					
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in whe finneral director, page 2 should be detached for use as the burial - transi	ပြီ	29a. Certifier . 2 outs to Devicine Te the best of my knowledge, death occurred at the time, date and place.	and due to the caus	se(s) and manner as	stated.
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To T	Med	and manner stated. 29b. Signature and title of certifier 29c. License number			(Month, Day, Year)
	_	O.C.M.E.		October 29, 2	2007
		30. Name and address of person who completed cause of death (Item 23a)			
5		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
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Usual Residence of Decedent 10a. State 10b. County Maryland Prince George's Hyattsville 10c. City, Town or Location Hyattsville 10c. City, Town or Location Hyattsville 10c. Street and Number 7202 Adelphi Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent's Hispanic Origin? (Specify Yes or No-Riack, White Status) 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Education 15. Decedent's Usual Occupation 15. Decedent's Education 15. Decedent's Usual Occupation 15. Decedent's Usual Occupation 15. Decedent's Education 15. Decedent's Usual Occupation 15. Decedent's Usual Occupation 15. Decedent's Education 15. Decedent's Usual Occupation 15. Decedent's Education 15. Decedent's Usual Occupation 16. State 15. Decedent's Usual Occupation 16. State 15. Decedent's Usual Occupation 16. Decedent's Usual Oc	thplace (State or Foreign ountry)
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	Approximate
Physician Immediate Cause (Final disease or condition Cardiac Arrythmias	Interval Between Onset and Death
/Medical resulting in death) Due to (or as a consequence of):	
Examiner Sequentially list conditions, Due to (or as a consequence of :	
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25. Was case referred to medical examiner? 1	ecify)
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 38b. Time of Injury 48b. Time of Injury 48c. Injury at Work? 48b. Time of Injury 48c. Injury at Work? 48b. Time of Injury 48c. Injury at Work? 48b. Time of Injury 48c. Injury at Work? 48b. Time of Injury 48c. Injury at Work? 48c. Injury at Work?	
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Second Property of the Control of	urai Houte Number,
	s stated.
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number e to the cause(s)	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Months)	. 5
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	th, Day, Year)
Dr. Sayed Elsayyad, MD 9715 Medical Center Drive, Rockville, MD 2085	th, Day, Year)
State Registrar 31. Date filed (Month, Day, Year) 12. Registrar's Signar fre	107

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 2007 8:45 P M CLARA NAOMI ROSS /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HARFORD ABERDEEN 124 MT. CALVARY CHURCH ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 💢 F Yrs MAY 4, 87 MARYLAND 218-22-0940 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show ast be notified at 1 X Yes 2 No ABERDEEN MARYLAND HARFORD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 124 MT. CALVARY CHURCH ROAD or Items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner: Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Manager 2000. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: BLACK Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done do life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) VA HOSPITAL WARD LEADER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET PARKER CHARLES JONES 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 124 MT. CALVARY CHURCH ROAD, ABERDEEN, MD 21001 GRACE E. WILSON / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 10/27/07 ABERDEEN, MARYLAND CALVARY UAME CEM `4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 21. Signature of Funeral Service Licensee need 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician arcinomo disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2000 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2] No 2 No 1 Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred i Director: After t d in by the funera Certification: Injury 1 Natural 5 Pending 2 🗆 No 1 Yes investigation death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 24 hours a 1 Pertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier nause of deat 30. Name and address of person strar's Sign State 2 3 OCT Registrar

	_	For State Registrar			State C	/ IVIO	ii yiaiiu		tificate of				Reg. N	200	7	35	659
Physicia /Medica	n al	1. Decedent's Name Audr	ey]	L.		se		4b. City, Town,	or Loopt	ion of Dooth	2. Date of D Month Octob	er	Day 21 4c. County	Year 2007		e of Death 15 P M
Examine	r	4a. Facility Name (If Montgomer				,	are		Montgo			σe		Monte		v	
Funeral Director		5. Social Security Nu 232-16-8	umber 225	6. Sex	M 2 X F		(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Day	r If Un	ider 24 Hrs.	-			9. Birtho	lace (Sta	ite or Foreigr rginia
and and		Usual Residence of I 10a. State	Decedent 10b. County				10c. City,	Town or Lo	cation						1	Od. Insid	e City Limits
Maryt a-f sho ifled a	بخ	Md.	Мо	ntgo	mery		1	Derwo	ođ							1 🗆 🗅	∕es 2X No
3a or 28	Funeral Director	10e. Street and Num 17809 Te:		ve					10f. Zip Code		855		10g. (Citizen of V Un	Vhat Cour		tes
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funera	11. Marital Status 1 Never Marrie 3 Widowed		1	2. Was Dec Armed F 1 ☐ Yes If Yes, G Year or D	orces? 2 X N ive			Vas Decedent of f Yes, specify Cu I □ Yes 2 N			ecify Yes or N Rican, etc.)	lo-		e - Americ k, White,		1,
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1 and 2 sho Health and I em 27 is ma ther traums		19a. Informant's Nat Carolyn				hte:	r		g Address <i>(Str</i> e 09 Teri							Code)	
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permit. Departm Importa any Inju		21. Signature of Fur		License	Ba	rh	w	22	Name and Add Muriel P. O.	ress of F H. B	acility Barber	Funera	l H	ome	Md.	2088:	2
Physician /Medical Examiner as the private ransit as the burial-transit	fedical Examiner	23a. Part1. Enter the shock, or hear Immediate Cause (f disease or condition resulting in death) Sequentially list con if any, leading to immediate. Enter Under Cause (Disease or it that initiated events resulting in death) Light	t failure. List Final I	a. b. c.	Due to	or as a constant of the consta	e. (<u>A</u>)(a conseque	once of): Observe of):	PNEW tructive Dem	moi e	nia Pulm	or respiratory		1380	56	Approxi	mate Between and Death
death cer ne attendir ed for use	sician/N	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 🎉 9 □ Unknown	months?	23		birth nant at	pf pregnand 2 ☐ Fetal d time of dea	leath 3□	Ectopic pregnar	ncy					te of delive	ery Day	Year
res that igned by be deta	by Phy	Part II. Other signifi	cant condition	ons cont	tributing to o	leath bu	ıt not result	ing in the u	nderlying cause	given in P	art I.			o use cont			of death?
The law requires tate has been signe page 2 should be	Completed											24a. Wa aut per	s an opsy formed:	24b.	Were auto prior to co death?	psy findi	ngs available of cause of
sician: Th certificate rector, paç	Se l	25. Was case referre	ed to medical							26. F	Place of Deat	1 Yes h (Check only		NO	1 □ Yes	2 No	
Physic this ce al dire	2	1 ☐ Yes 2 ☑ 1		Ho		Inpatie			LOUDON		Nursing Ho	ome 5□Re				y)	
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director, After th completely filled in by the funeral	Certification:	1 Natural 2 Accident 3 Suicide	5 ☐ Pendin investio 6 ☐ Could r	gation not be		nth, Day	Year)	28b. Time of Injury	W	□Yes	2 🗆 No	28d. Describe 28f. Location				al Boute	Number
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To To To To I	Σ	29b. Signature and t	title of certifie	flu	enos		Mi	Ci	29c. Lice	nse numl 31				Date signe		Day, Yea	2007
4		30. Name and addre							Print) derick	Ave.	, #413	, Gait	hers	sburg	, Md.	20	877
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DHMH 17 Rev 1/2001

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/Medic Examin	- 40	Kevin Ra 4a. Facility Name (I Holy Cro	If not institution, gi		mber)		4b. City,			f Death	OCLOD	4	c. Count	y of Deatl) F ···
Funeral Director		5. Social Security N	lumber 6.	Sex 1XM 2□F	7. Age (In yrs. 49		If Under Months	Days	If Under 2 Hours	Min.	8. Date of B (Month, D Sept 1	av. Yea	⁽⁷⁾ .958	Cor	hplace (State of untry) ington,	_
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within 24 hours after death. To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2 s	-	27. Manner of Dea 1 X Natural 2 Accident	th 5 ☐ Pending investigati	28a. Date (Mon		28b. Time of Injury		Bc. Injury a Work?		2	28d. Describe				City)	-
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5)	2	10	bara s	upan	-	m, l	UD DE	55485	number			290. 1			h, Day, Year) 2 - 0 7	7
happo		30. Name and add	_				4 n	. Si	lver	Spr	ing. M	D 20	910			
Sta Registr		Barbara 31. Date filed (Moi	OCT 24	2007 32. 5	gistrar's Signa	ature	berle	<u> </u>								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month ROBIN L. SHORT OCTOBER 28 2007 318 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) 12/5/1962 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Hours 1 □ M 2 🕅 F 187-58-9790 44 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Whiteford MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4060 Prospect Road 21160 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Senior Account Executive Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mabel Blankenship Samuel Wendall Ward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry L. Short/Husband 4060 Prospect Road, Whiteford, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐Removal from State Evans Eagle Crematory 11/2/2007 Leola, PA 4 □ Donation 5 □ Other (Specify) 21. Signatue of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA Part. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) artenosclero Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

 $\Delta HOAT$ ROBI Baltimore, Maryland 21215-0036

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Funeral

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care has teen signed by page 2 should be detact funeral director, After this

M 80034 (350 /0/28/07 03) Division of Vital Rec<mark>o</mark>rds, P.O. Box 68760

Examine Physician/Medical Be Certification: To

Completed by

25. Was case referred to medical

1 XYes 2 No

Manner of Death

1 Natural

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

examiner's

To the Hospital or Attent within 24 hours after death To the Funeral Director:

State Registrar 28c. Injury at Work?

2 X ER/Outpatient 3 □ DOA

28b. Time of

Injury

1∐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 7 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year tober 200+ DEBORAH ELLEN SMITH 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) P ivista If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) (State or Foreign 7. Age (In yrs. last birthday 5. Social Security Number Year) Months Davs Hours 1□M 2QF 15,1952 JULY 55 WASH. D.C. 219-58-8716 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes Mo CHARLES WALDORF MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A. 20603 6070 A THOROUGHBRED COURT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) FEDERAL GOVERNMENT ACCOUNTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY ELIZABETH ELLIS KENNETH LEON SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 40 SILVER SPRINGS, FL 34488 DAWN LONG / DAUGHTER 16440 E. HWY. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2☐€remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CRE. 10/31/07 ALEXANDRIA, 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service License our Balo MD 20646 M006415635 WASHINGTON AVE.LA PLATA, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ю Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown

Examiner be executed sician and burial-trans Box 68760. physician a attending p as P.0. the ò signed by Division or Vital Records, certificate has page 2 Physician: this

Hospital or Attending death.

Examiner Physician/Medical by Completed Be Certification: To funeral After t within 24 hours after death To the Funeral Director: filled in by

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

or items 23a

other traumatic event, the Medical Examiner

Hygiene.

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Department of Important: If it any Injury or c

Physician /Medical

Pages 1 and 2 should be

Director

Funeral

Completed by

Be

2

death with the Maryland

filed within 72 hours after

and

Baltimore, Mary

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25.	Was case referr	ed to medical						26. Place of Dea	th Check onl one	
	examiner? 1 ☐ Yes 2	No	Hospital	1 Inpatient 2	ER/Outpatient	3 🗆 🛭	OA	Other: 4 Nursing H	lome 5 Residence 6	Other (Specify)
	Manner of Death	5 □ Pending investigation		Date of Injury (Month, Day Year	28b. Time of Injury	М		Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	t be 290 Place of injury - At home farm street factor					ffice	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29	a. Certifier (Check only one)	1 Certifying Pt 2 Medical Exa	niner: O	To the best of my n the basis of exam d manner stated.	knowledge, death nination and/or inve	occurre	d at t	the time, date and place my opinion, death occu	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)

Medical 29b. Signature and title of certifier

State Registrar

10

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rd Waldorf 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 6:10AM OCTOBER 29 2007 THERESA ELIZABETH SWANN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS LA PLATA CENTER CHARLES LA PLATA Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖵 F Director 579-34-6473 OCT.31,1925 MARYLAND Usual Residence of Decedent Worle 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiane. Important: if item 27 is marked other then "neturel", or iteme 23a or 28a-f ehoven in july or other traumatic event, if a Medical Examinate must be notified at once. 1 ☐ Yes 2X Xio Funeral Director CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? NUMBER 1 MAGNOLIA DRIVE S. A. 20646 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 € Wivorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 COUNTER CASHIER DRY CLEANERS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ WALTER T. SWANN MARY LOTTIE PROCTOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEMETRIA T. CARTER/DAUGHTER 11430 STONEY PT.PL. GERMANTOWN, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST.JOSEPH'S CEM. 11/03/2007 POMFRET, MD 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Immediate Cause (Final) Interval Between Onset and Death Congestive Heart Immediate Cause (Final disease or condition resulting in death) **Physician** days /Medical Due to (or as a consequence of): Diabetes Mellitus Examiner Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? COPD, Smoker, CKD 1 Yes 2 □ No 3 Probably 4 □Unknown Completed Lyperlipidemia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Bladder cancer 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending after death.
Director: Aff investigation 1 □ Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral D completely filled in the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061614 Octuber 29, 2007 RSINDHWAND WALDORF, MB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

SQUARE

PEMBROOKE

32. Régistrar's Signature

11350 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT 2 3 2007

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08150 State of Maryland / Department of Health and Mental Hygiene Daniel Sutton 35665 Certificate of Death Rea. No Registrar 3. Time of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 19, 2007 0950 hrs Medical Examine DAN H. SUTTON 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Havre de Grace Harford Harford Memorial 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Days Hours Min Months Director 221-40-9072 52 6/30/1955 Country) DE 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits IOc. City, Town or Location 10a State Ob. County 1 X Yes 2 No MD Harford Havre de Grace 28a-f show "natural", or items 23a or 28a-f shov Examiner must be notified at once. more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nen of Health and Mental Hygiene. Director 10f. Zip Code 10g. Citizen of What Country 10e, Street and Number 805 Giles Street 21078 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 X Never Married 2 Married 1X Yes No White Yes, Give Yeer Yes Specify 2 No specify Widowed Divorced "natural", ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical Apprentice Plumber Building Trade marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ARTHUR H. SUTTON BERNICE FRAIM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i BEVERLY S. POTTER Sister 1110 SHELDON DR, NEWARK, DE 1971] 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a, Method of Disposition crematory or other place) Department of He Important: If it in injury or other t Burial 2 X Cremation 3 Removal from State EVANS CREMATORY 10/23/2007 LEOLA, PA Donation 5 Other Specify 22. Name and Address of Facility 19809 21. Signature of Funeral Servicensee BEESON FH, 412 PHILADELPHIA PK, WILMINGTON, DEApproximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ Yes 2 No 3 Probably 4 ✔ Unknown Chronic alcoholism Completed 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed' death? 2 No page Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be Otherexaminer? Nursing Home 5 Residence 6 Other Inpatient 2 FR/Outpatient 3 this ို 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury (Month, Day, Yeer) 28b. Time of Injury Certification: 1 V Natural Division Yes 2 No Pending death. filled in by the the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 3 6 Could not be or Town, State) Suicide determined Homicide 29a. Certifier 1

Registrar DHMH 17 Rev 1/2001

To the Func

Medical

State

Signature and title of certifier

Patricia Aronica-Pollak MD.

31. Date filed (Month Pay, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 20, 2007

200

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner

strar's Signature

BRUKEN

		1	For State Registrar	State of N	Maryland / [Departmen <i>Certificat</i>				jiene _{leg. No.} 2 N	0.7	35666
	W. 8		Decedent's Name (First, Middle	, Last)					2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		Harold Stanle	ey Shiles					10	19	07	1805 M
>	Examin	/	4a. Facility Name (If not institution	, give street and numbe	er)	4b. City,		ation of Death		4c. County	of Death	(i)
M			Peninsula Region	AL MEDICAL		·		Sharaf		-		
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. last bit	Yrs. If Unde Months		Under 24 Hrs. ours Min.	8. Date of Birtl (Month, Day	/, Year)	Cour	**
	Director		218-07-6013		93	115.			Sept. 2	9, 1914	Mar	yland
	w w	-	Usual Residence of Decedent 10a, State 10b. County		10c. City, Tow	n or Location					1	0d. Inside City Limits
	faryk sho ed at	5	MD Wice	omico	Mard	ela Spri	nas					1 ∐Yes 2⊠ No
	the N 28a-i notifi	Director	10e, Street and Number		Hara	10f. Zij				10g. Citizen of V	/hat Cour	ntry?
	with sa or t be		25980 Delmar Ro	nad			21837			U.S.A	_	
	ns 23 mus	Funeral	11. Marital Status	12. Was Decede		13. Was Dece		nic Origin? (Spe Mexican, Puerto I	cify Yes or No-			can Indian,
	r Iter or Iter or Iter or Iter		1 ☐ Never Married 2X Marr	Armed Force	s? □ No 1943 -	1 ☐ Yes		pecify:	nicari, etc.)	Specify		nite
ğ	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date:	s: 1946	I Lites	2E3 NO 0)	респу.				
<u>ဂ</u>	72 ho natui lical	Completed	15. Decedent	t's Education st grade completed)	16a	. Decedent's Usu (Give kind of wo	al Occupation ork done durin	n ng most of workin	ng	16b. Kind of Bu	siness/In	dustry
2	thin ie.	nple.	Elementary/Secondary (0-12)	College (1-4d	or 5+)					T .		
2	be filed within 72 hours after death with the Marylan Hygiene. d altygiene. d other than "natural", or Items 23a or 28a-f show event, the M-dical Examiner must be notified at		11	(Sale	sperso		(First Middle	Maiden Surnan		e Company
D L	be fill ntal H id oth even	Be	17. Father's Name (First, Middle,	Last)			10.			obinson	-,	
Maryland 21215-0036	should I and Men s marker umatic	٤١	John T. Shiles 19a, Informant's Name/Relations	phin (Time Print)	19	b. Mailing Addres	s (Street and				State, Zi	o Code)
<u>a</u>			Sadie W. Shiles		i	25980 De				Springs		21837
	1 and 2 Health em 27 i		20a. Method of Disposition	5 (WIIC)	20b. Place of	of Disposition (Na	me of		ate	20c. Location -		
nor	Pages nent of h ant: If ite ary or of		1 ABurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate I	ery, crematory or en's Cem		Oct 24	2007	Sharpton	ωn. ľ	Maryland
Baltimore,	artme ortani injun		21. Signature of Funeral Service		TITCH	22. Name a	nd Address of	f Facility	, 2007	bildipto	1119 1	lary rand
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 Air	1 1		Short 13 Eas	Funera t Grove	1 Home e St.	Delmar,	DE 199	940	
n.		-	23a. Part1. Enter the disease, shock, or heart failure. List	complications that cau	sed the death. Do	not enter the mo	de of dying, s	uch as cardiac o	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause Imnal		riscler							Onset and Death
þ	/Medical		disease or condition resulting in death)		as a consequence		NI LUVI					
	Examiner			h								
- 29		ner	Sequentially list conditions, if any, leading to initialle cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a consequence	i clj:						
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	с							\rightarrow	
Ö,	e exe		resulting in death) Last	Due to (or	as a consequence	e of):						
8760,	cate be executed physician and the burial-transit	dical		d								
9	ertific ling p	Me	IF FEMALE:	220 If yes outes	ome pf pregnancy					22d Da	ate of deliv	(en)
Вох	ath c	jan/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birt	th 2 Fetal dea nt at time of death	th 3 ☐ Ectopic 5 ☐ Other (s					onth	Day Year
0	ne de the a	/sic	1 Yes 2 No 9 Unknown	9□Unknow		3□Other (specify)					
Δ.	that the	by Physician/Me	Part II. Other significant,conditi	ions contributing to deat	th but not resulting	in the underlying	cause given i	in Part I.	23e. Did	tobacco use con	tribute to	the cause of death?
ds,	The law requires that the death certific the has been signed by the attending I bage 2 should be detached for use as	db	renal freu	line					10	Yes 2 No	3 ☐ Pro	obabły 4 □Unknown
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Re	he lay ge 2	E D	Codilli	O FILLETT	- 1	A	_			ormed?	prior to c death? 1 \Boxedarrow Yes	ompletion of cause of 2 □ No
ā	ificate		25. Was case referre o edica	al College	2). 1 al	NINCHAR	m ·	6. Place of Deat	l 1 Yes	2 No one	1 🗆 163	2010
5	Physician: this certific ral director,	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 / inp	patient 2 ☐ ER/C	Outpatient 3 🗆 🛭	Othor			idence 6 □Ot	her (Spec	cify)
ō	g Phy er this eral c	7: To	27. Manner of Death	28a. Date of		. Time of Injury	28c. Injury at Work?			how injury occu		
<u>0</u>	Attending r death. ector: After	aţjo	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	tigation (World)	, Day Your,	M		s 2□No				
Division or Vital Records,	Fr degree or deg	Hic	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	minod ZOE, Flace U	of injury - At home, g, etc. (Specify)	farm, street, facto	ory, office		28f. Location City or To	(Street and Num own, State)	ber or Ru	ral Route Number,
	rs after at Dire	Certification:		1								
	the Hospital hin 24 hours a the Funeral upletely filled		(Check only 2 Medica	ing Physician: To the basel Examiner: On the base	sis of examination	ge, death occurre and/or investigati	ed at the time, on, in my opin	, date and place, nion, death occu	, and due to the rred at the time	e cause(s) and m e, date and place	, and due	to the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one) 29b. Signature and title of certifi	and manne	er stated.	2	9c. License n	umber		29d. Date sign	ed (Monti	h, Day, Year)
			200, Organization of Continu	-1.001)0.	200-1-2		D1538	84		inla	11/1	17
	NYVAX		30. Name and address of person	n who completed cause	of death (Item 23a	(Type, Print)		•		10/2		
	11. Do		Rodney WENRIC	Luni 11	DOF CARI	WLL 51	. SAL	isbueu	mel.	2180	/	
	St	ate	31. Date filed (Month, Day, Year	4 0007	gistrar's Signature		5,11	7			-	
	Regist		OCT 2	4 2007	10.00	Brank	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death EDWARD SAVACE 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Savage Day Month **Physician** CALVIN 0418 M 10 07 /Medical Racility Name (If not institution, give street and number) 4c, County of Death Examiner 4b. City, Town, or Location of Death Diconce eninsula Regional Medical alisbury Lenter if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□F 59 FRANKFORD, DE 221-30-2831 JAN 16,1948 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at SUSSEX COUNTY DELAWARE 30019 R FARM LANE MILLSBORO, DE Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be no once. 10g. Citizen of What Country? R FARM 19966 UNITED STATES LANE Funeral 12. Was Decedent Ever in 1967. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 N YES if Yes, Give YICS Year or Dates: KOKE 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ፩ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 HORSEMAN/GROOM HORSERACING STABLES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES EDWARD SAVAGE, SR. HATTIE ELLA **ENNIS** ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY MURRAY 27113 MT. JOY RD., MILLSBORO, DE 19966 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Tremation 3 ☐ Removal from State CREMATORY OF DELMARVA OCT 24,2007 DELMAR, DE 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Idcensee 22. Name and Address of Facility MO1365 WATSON FUNERAL HOME P.O.BOX 125 MILLSBORO, DE 23a. Part1. Enter the Viscose, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mocardial /Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 1∐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29a. Certifier (Check only one) 290. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/20/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury MD 21801 State Registrar

	0.1.	1 State Amend It 1. Decedent's Name (First, Midd.	State of em 24a per	dr.,g8	14,46	tificate	i dibi	Death	-	2. Date of Deat			3 5 6 6 8
Physi	ian	Edward	o, Lavy	Stick	ro1					Month Octobe	Day	Year 2007	М
/Med Exam		4a. Facility Name (If not institutio	n, give street and nun		reı	4b. City,	Town, or	Location of	of Death	octobe		inty of Deat	h
Exam	ii iei	11013 Riverton				Mar	dela	Spri	inas		Wi	comic	0
Funera		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under Months		If Under:		8. Date of Birth (Month, Day,	Year)	9. Birt	hplace (State or Foreign
Directo		216-34-4689	1 x M 2□ F	70	Yrs.	IVIOTILIS	Days	110013		5/19/19	37		ryland
and w		Usual Residence of Decedent 10a, State 10b, County	,	10c. City.	Town or Lo	ocation					-		10d. Inside City Limits
daryli f eho	ō	Maryland Wice	omico	Mar	dela	Sprin	as						1 ☐ Yes 2X No
the 1	Funeral Director	10e. Street and Number				10f. Zip				1	0g. Citizen	of What Co	ountry?
3a or	i i	11013 Riverton	n Road				2183	7			USA		
deat	nera	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S	S. 13.	Was Deced	ent of His	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Ame Black, White	rican Indian,
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iteme 23a or 28a-1 ehow any injury or other traumatic event, the Marylan Examinat must be notified at		20a. Method of Disposition 1 Burial 2X Cremation		State C6	metery, cre	matory or o	ther place						
Hin Partment and any orders		4 Donation 5 Other (3		Sal	lisbur			-		23/07		sbury	
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		23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that c t only one cause on e	aused the death ach line.	. Do not en	ter the mode	e of dying	g, such as	cardiac o	or respiratory arm	est,		Approximate Interval Between Onset and Death
Physicia		Immediate Cause (Final disease or condition resulting in death)	_a_ W	Austa	Tu	lun	0)	M					6 mo
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Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical		ing Physician: To the I Examiner: On the band mani										
To the within To the	Me	29b. Signature and title of certifi		\wedge				e number					th, Day, Year)
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U VM		30. Name and address of person	1. PKA22.	0 10	15 1	Erint)	ARR	ou.	24	SAUS	BM	y N	γ
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			For State Registrar	State of Ma	ryianu	•	rtificate o			-	Reg. No.	007	356	569
*	Physicia		1. Decedent's Name (First, Middle, La	ist)						Date of De Month	ath Day	Year	3. Time of	Death
	/Medic		Juanita E. Tate				,			Octobe	r 18,	2007	9:15	РM
	Examin	er	4a. Facility Name (If not institution, gi	,			4b. City, Town					unty of Death		
			St. Thomas More No. Social Security Number 6.		ehabil (In yrs. last			attsvi	-	MD 8. Date of Bir		ice Ge	orge's	or Foundam
	Funeral Director			1□M 2⊠F 73	(III yrs. iasi	Yrs.	Months Day			(Month, Da Feb. 7	ıy, Year)	Cot	untry)	or roreign
	put w		Usual Residence of Decedent 10a. State 10b. County		10c, City, T	own or Lo	ocation						10d. Inside C	ity Limits
	Maryla t-f shor	tor	DC Tool County		,,,		of Colu	mbia						2 □ No
	th the	Director	10e. Street and Number				10f. Zip Code	9			10g. Citizen	of What Co	untry?	
	ath wi		3322 14th Street				2001				USA			
36	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		i	Was Decedento If Yes, specify C 1 □ Yes 21√2 N			ecity Yes or No Rican, etc.)		Race - Amer Black, White ecify: R1		
8	2 hour atural cal Ex		15. Decedent's E	ducation	1	6a. Dece	dent's Usual Oc	cupation			16b. Kind	of Business/I		
Maryland 21215-0036	filed within 72 Hygiene. Ither than "nai ant, the Medice	Completed	(Specify only highest gi	ade completed) College (1-4or 5-		Give life. i Homem	kind of work do DO NOT use ret	ne during mo ired)	ost of work	ing	Solf-	-emplo	ved	
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au		To Be	Norman Coleman	,						urner	,	ŕ		
ary	d 2 should th and Mer 7 is marke traumatic	۲	19a. Informant's Name/Relationship	(Type. Print)	1	19b. Mailir	ng Address (Stre				er, City or To	own, State, Z	ip Code)	
	DEST		Tyrone Tate/Son				verbirc		Sha	rpsburg	, GA	30277		
o	ges 1 and t of Healt If item 2 or other	1 8	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [TRemoval from State			osition (Name of matory or other p			Date		on - City or		
Ē	Pages tment of tant: If its fury or o		4 ☐ Donation 5 ☐ Other (Spec	fy)	Metro	•	tan Crem							
Ba	permit. Pages Department of I Important: If ite any Injury or of		21. Signature of Funeral Service Lice	shall.			2. Name and Ad 217 9th						ome, In	nc.
			23a. Party Enter the disease, or cor shock, or heart failure. List only										Approxima Interval Be Onset and	tween
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	/Medical Examiner		1	Due to (or s	consequen	ice of):							ı	
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			IF FEMALE:	23c. If yes, outcome p	of pregnancy	,					224	. Date of deli	ivon	
Вох	attending	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal de	eath 3	⊒Ectopic pregna ⊒ Other <i>(specify)</i>				230	Month		Year
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Records, P	res t igne be c	þ	Part II. Other significant conditions	contributing to death bu	t not resultir	ng in the u	nderlying cause	given in Par	t I.	23e. Did	/		the cause of obably 4	
000	law require las been sig	plete								24a. Was		4b. Were au	topsy findings	available
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Division or	I or Attend after death. Director: /	Certification:	3 Suicide 6 Could not to determined	e 290 Blood of inju	ry - At home	e, farm, str				28f. Location (Street and N wn, State)	lumber or Ru	ıral Route Nut	mber,
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	e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certific letely filled in by the funeral director,	Medical		hysiclan: To the best o miner: On the basis of and manner sta	examination									(s)
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)	(4)		30. Name and address of person who	completed cluse of de	ath (Item 23	Ba) (Type,	Print) AS Q			Λ.	11	++-	Achi	\ \
	//		31. Date filed (Month, Day, Year)	32 Renietra	r's Signatur	42	05 Qc	reen	2 1700	4/24	M99	14501	1100	120
	Sta Registr		OCT 2 3 2007	32. Registra	bose	de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 10/20/2007 NAOMI MAE CHAPMAN TARR 1:00 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Pocomoke City Hartley Hall Nursing Home Worcester If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours 1 □ M 2 X F 12/15/1920 86 219-05-9107 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MD Worcester Pocomoke City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2438 Stockton Road 21851 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Spencer Chapman Nettie Olivia Tull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Howard (daughter) 768 Cedar Hall Road, Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Salem Methodist Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10/22/2007 Pocomoke City, MD Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

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Division or Vital Records, P.O. Box 68760,

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Hospital or Attending Physician: The law requires that the death certificate be executed s after oc. within 24 hours a

To the Funeral Completely filled the

BA 12 State

Registrar

Medical

29a. Certifier

(Check only one)

1 Yes 2 No

27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 3∏ Suicide 4 Homicide

6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

10-20-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manke

65 31. Date filed (Month, Day, Year) OCT 24 2007

29b. Signature and title of sertifier

			1 _ For	State of Marylan						•	iene		05671
			Registrar		Ce	rtifica	te of L	Death			og. 140.	7	35671
4	Physici	an	1. Decedent's Name (First, Middle, Last) Donald Charle		Sr.				2	2. Date of Dea Month	Day	Year	3. Time of Death
	/Media	cal	4a. Facility Name (If not institution, give s		SL.	4b Cib	Tour or	Location of D	Donth	Octobe	r 18, 2		2:40
100	Examir	er	600 Bowman Drive	street and number)			alisb		Jeath		Wico		
	Funeral		Social Security Number 6. Sex		ast birthday)	If Unde	r 1 Year	If Under 24		. Date of Birth	1		place (State or Foreign
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	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. Cih	, Town or Lo	ocation							10d, Inside City Limits
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	1 the 7	rect	10e. Street and Number	<u> </u>	a11500	-	ip Code			1	0g. Citizen of V	Vhat Cou	ntry?
	th with	Funeral Director	600 Bowman Drive				21804	;			USA		
	eme FE	Iner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Dece	edent of His	spanic Origin n. Mexican, F	? (Speci	fy Yes or No- can, etc.)		e - Ameri	can Indian,
36	or it	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give			2 X No				Specify		white
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or iteme 23a or 28a-f ehow event, tra Madical Exam har must be notified at	ed b	15. Decedent's Educ	Year or Dates:	16a. Dece	dent's Usi	ial Occupa	ation			16b. Kind of Bu		
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21	ad with	Completed	12		hors	e tra	ainer				horse	trai	ning
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)								Maiden Sumam	a)	
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Maryland	d2st than 7 ien traun		19a. Informant's Name/Relationship (Type Judith S. Trivits)		1	_					, City or Town, D 21 804		Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or iteme 23a or 28a-f ehow amy injury or other traumatic event, the Medical Exam are must be notified at any injury or other traumatic event, the Medical Exam are must be notified at any injury.		20a. Method of Disposition	20b, P	lace of Dispo	sition (Na	ame of	1	Dai		20c. Location -		own, State
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Baltimore,	mit. F partm sortar / injus		21 Signature of Funeral Service License	99	Park	Name a	nd Addres	'		-			sociation
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P.O. Box	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1☐Live birth 2☐Fetal	death 3[oregnancy				23d. Dat	e of deliv	ery Day Year
<u>.</u>	he de r the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	eath 5	Other (s	pecify)						
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Division of Vital Records,	quires n sign	d by								1 🗆 Ye	s 2 100	3 Pro	bably 4 Unknown
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Z U	ding F	lon:	27. Manner of Death Solution	28a. Date of Injury (Month, Day Year)	28b. Time o fn j ury	f M	28c. Injury Work	at :? ∕es 2 ⊡No		d. Describe ho	w injury occurr	be	
Sic	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me farm str					f. Location (SI	reet and Numb	er or Rur	al Route Number,
<u>S</u>	at or / after Dire d in b	Certification:	4 Homicide	building, etc. (Specify)	001, 10010	,,			City or Town	, State)		
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	To the Hospital or Attanding Physician: The i within 24 hours after dadh. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	ledical	UNE)	ner: On the basis of examinat and manner stated.	ion and/or in				occurred				
	To To	Σ	29b. Signature and title of certifier			29	c. License	number	41	0 2	9d. Date signed	(Month,	Day, Year)
	G and		300		n		00	038	7/		10-17	5 - (/ /
	MIS	Į	30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	3	Po Bo	×	# 173	3 SH	Lisa	19 yus 210)
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/Medical Examiner

Examiner Physician/Medical Be Completed by Hospital or Attending Physician: 24 hours after death. Certification: To 24 hours after death e Funeral Director:

The law requires that the death certificate be executed

24, TEOFILL A, OLLYSLAN. LOLIGICT

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Respiratory Failur Due to (or as a consequence of): c. Heart Failure with Due to (or as a consequence of): d.		tion			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		Ectopic pregnancy Other (specify)	2	3d. Date of delivery Month Day Year		
Part II. Other significant conditions	contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?		
Renal Failure		*	1 ☐ Yes 2∑	☑ No 3 ☐ Probably 4 ☐ Unknow		
			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)			
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 XInpatient 2 ☐ ER/Outpatient	S □Other (Specify)				
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred		
3 Suicide 6 Could not be determined		eet, factory, office	actory, office 28f. Location (Street and Number or Rural F City or Town, State)			
29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of my knowledge, death miner: On the basis of examination and/or inv and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause(s) rred at the time, date and	and manner as stated. I place, and due to the cause(s)		
29h Signature and title of certifier		29c. License number	29d. Dat	e signed (Month, Day, Year)		

D 66066

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4:45 A.M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 X No

Philippines

Filipino

2007

Montgomery

4c. County of Death

10g. Citizen of What Country?

Specify

16b. Kind of Business/Industry

Home

20c. Location - City or Town, State

United States

Race - American Indian, Black, White, etc.

19,

1923

State Registrar

completely within 24

Medical

Andrew Wong, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year)

ancher Wor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

29b. Signature and title of certifier

32. Rejistrar's Signature

To the Hospital within 24 hours a To the Funeral C

State Registrar 29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Yee 007 2 3 2007

7330 VANDUSEN RD, LAUREL, MD-20707 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0064539

29d. Date signed (Month, Day, Year)

			For State	State of Marylan	_	artment of F <i>rtificate of</i>			2007	25671
		-	Registrar 1. Decedent's Name (First, Middle	e. Last)	Ce	runcate of	Deam	Reg.	. No.Z U U /	356/4 3. Time of Death
	Physici /Medic		Louis	R. White				October	Day 7, 2007	609 M
	Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	
			Doctors Hospit			Lanhar			Prince Ge	orge's
100	Funeral Director		5. Social Security Number 224-38-7980	6. Sex 7. Age (In yrs. 74	last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, You August 4	ear) 9. Birthp Court 1933 Virg	
	P.		Usual Residence of Decedent							
	arylar show d at	-	10a. State 10b. County		y, Town or Lo	ocation			1	0d. Inside City Limits 1 ⊊Yes 2 ☐ No
	he M 28a-f otifie	ectc	MD Princ 10e. Street and Number	e George's La	nham	101 7:- 0-1-		10-	Citizen of Miles Court	
	with a or the n	Funeral Director	6515 Dawnwood			10f. Zip Code 20706			. Citizen of What Cour	ury:
	death ms 2%	Jera	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (Sp		14. Race - Americ	
24/5 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married	Armed Forces? ied in Yarmed Forces? If Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	an, Mexican, Puerto	Hican, etc.)	Black, White,	_{etc.} Lack
50	72 ho natur dical	eted	15. Deceden	t's Education st grade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	pation during most of work	sina 16	b. Kind of Business/Inc	dustry
212	vithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				I .	0	
	be filed v ntal Hygie ed other t event, th		17. Father's Name (First, Middle,	5+ (ast)	Civ	il Engine		e (First, Middle, Ma.	Government	
land	uld be i Aental I rked oi tic eve	To Be	James E. White	,				na Hart	acin camaine,	
Mary	and 2 should ealth and Men n 27 is marke er traumatic		19a. Informant's Name/Relations Kendall White/			•			City or Town, State, Zip	Code)
ore,	es 1 a of Hei		20a. Method of Disposition		Place of Disponentery, cre	osition (Name of matory or other place	ce)	Date 20	c. Location - City or To	wn, State
SE	Pages ment of I ant: If ite ury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S						rlington, V	
$\mathcal{U}h$ Baltimore,	permit. Departr Importa any Inji		21. Signature of Funeral Service	Consee					ins Funera r,Maryland	
- 6			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the death only one cause on each line.	n. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a Complicat	Jens	al Ke	ck I j	u-les		Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or s a consequence	uence of):)	,		
		ja l	Sequentially list conditions,	b. Due to (or as a conse	uence of):					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	^					_	
90,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):					
68760,	phy phy the	dica		d						
Box 6	leath certifi attending I I for use as	//Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna					23d. Date of delive	erv
	death	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		□Ectopic pregnanc □ Other <i>(specify)</i> _	y		Month	Day Year
P.0	at the de d by the etached	Phys	9 Unknown				. 5	00 0:11		
or Vital Records,	Physician: The law requires that the death certificate has been signed by the attending rail director, page 2 should be detached for use as	þ	Part II. Other significant condition	ens contributing to death but not result	ulting in the u	inderlying cause giv	ien in Part I.	23e. Did tobac	cco use contribute to tl 2	ne cause of death? pably 4 Unknown
00	w req	lete	C4, 10 4.	Sachal down	Citro	C colco.	Δ	24a, Was an	24b. Were auto	psy findings available
Re	sician : The law certificate has t irector, page 2 s	Completed	Singe.	and de co		<u> </u>		autopsy performe 1⊠ Yes 2□	prior to co	mpletion of cause of
<u>ta</u>	ian: rtifica ctor, p	0	25. Was case referred to medica				26. Place of Dear	th (Check only one)	110	20110
> _	Physic this ce al direc	To B	examiler? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 🔀	ER/Outpatie	nt 3□ DOA Oth	er: 4 Nursing H	ome 5 Residenc	ce 6 □Other (Specif	y)
0	ng ffe		27. Manner of Death 1 □ Natural 5 □ Pendin	28a. Date of Injury (Month, Day Year)	28b, Time of Injury	Wor	k?	28d. Describe how	injury occurred	triking hear
<u>S</u>	ttend leath. tor: /	cati	2 Accident investion 3 Suicide 6 Could in	not be	UA KAC		Yes 2 No	July and	et and Number or Rura	en fernite
Division	l or A after o Direc	Certification:	4 ☐ Homicide determ	building, etc. (Specify	y)	reet, factory, office		City or Town,	State)	4.814
	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the funer	a C		g Physician: To the best of my kno			me, date and place	, and due to the cau		
	he Ho in 24 I he Fu pletel	ledical	(Check only 2 Medical one)	Examiner: On the basis of examina and manner stated.	tion and/or in	rvestigation, in my o			e and place, and due to	the cause(s)
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Ž	29b. Signature and title of certifie	Andrada /	13/61 5	29c. Licens	e number	29d	. Date signed (Month,	Day, Year)
			Bundle	enle re	4mQ		1852	_ (crober	17 2007
CD-	160)		30. Name and address of person	who completed cause of death (Item	23a) (Type,	Print)	ection 1	20 1.1.		MD 2018
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	103 (Over	Sbury	प्स मापुध	rsulle	140 2018
	Registr	_	OCT 2 3 2007	tiencent & A	per					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2007 F. Weaver Oct 17, 7:41P Helen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Carriage Hill If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 🛛 F 90 March 11,1917 Director 459 16 1152 Usual Residence of Decedent wing 2 should be filed within 72 hours after death with the Maryland aith and Mental Hygiene.
27 Is marked other than "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the traumatic event the "natural" or the "natura 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 ☐ No Director Chevy Chase MDMontgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 United States 1 Primrose Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No White Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic evonce. ပ Walter C. Foote Bertha Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette W. Ruesch/Daughter 1 Primrose St. Chevy Chase, MD20815 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 10/24/07 National Crematory |Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc. arth 5130 Wisconsin Ave., NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failus. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia **Physician** /Medical Due to (or as a consequence of) Examiner Dysphagia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed Late effect of Cerebrovascular Accident attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown P.0. signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pate has bage 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1**X** Natural 1 ☐ Yes 2 ☐ No 2 Accident rilled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continued in the date of the cause of 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35579

DHMH 17 Rev 1/2001

State Registrar 20816

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan J. Miller MD 6844 Tulip Hill Terr., Bethesda, MD 32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a-c, a f per inf 9873 11.14-07 vt. State of Maryland / Department of Health and Mental Hygiene 0 0 7

35676 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 3:33 pm **Physician** Wagner 11206-12 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sali Sbury

If Under 1 Year | If Under 24 Hrs.

The Days | Hours | Min. Wilsonia Le lake /tospice at 8. Date of Birth (Month, Day, Year) April 11, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 577-07-3701 1911 Washington, Director 96 Usual Residence of Decedent 10b. County Wicomico 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location Salisbury 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Obepartment of Health and Mental Hygiene. Important: If lear 23 a or 28s-1 show any injury or other traumatic event, the Madical Examination and the analysing any symmetric results and the analysing a MD. 1 ☐ Yes 2 🛣 No Director St. Charles 300 Lemmon Hill Lane Rm. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 39 63301 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 基質 No 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No *Specify:* White If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elwood Pearson Caroline Lee Carter 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kaye Murphy/Daughter 3239 Canal Street, St. Charles, MO 63301 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition Parklawn Memorial October 23, Rockville, Ma
Park
2007
Francis J. Collins Funeral Home Inc.
500 University Blvd, W, Silver Spring, October 23, tx Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee DOC 8 MD 20901 ano 23a. Part1, anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MONIA Neu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner CLOSTRIDIUM burial-transit The law requires that the death certificate be executed DIFFICILA that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760 Completed by Physician/Medical as the IF.FEMALE: use 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 in the past 12 menths? Month Day Year 5 Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 20 No 1 🗌 Yes certificate 1 Yes or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28 Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral Medical Certification: After Division Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospitel Certifying Physiciam. To the bast of my knowledge, death occurred at the time, date and place, and due to the eause(s) and mainter as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO BOX 1733 SHLISBUR COASTAL YOSPICA CHULAM WARIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2007 Registrar

			For State of Maryla	and / Depa <i>Cei</i>	artment of H rtificate of I	lealth and Mo <i>Death</i>	ental Hygie		35677
	Dhysisi		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic	al .	Edward Russell Working				october 2		7 P M
	Examin	Ç.	4a. Facility Name (If not institution, give street and number) 13920 Sunrise Dr.			r Location of Death		4c. County of Deat	
	Funeral		5. Social Security Number 6. Sex. 7. Age (In)	rs. last birthday)	Hagersto If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo	Washingto	hplace (State or Foreign
	Director		218–40–3677 1 [™] 2□ F 75	Yrs.	Months Days		lay16 193		yland
	iand ow	}	Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary Fe f ah	tor	Maryland Washington County Ha	gerstown	ı				1X Yes 2 No
	or 28	Directo	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	ountry?
	a 23a	rall	13920 Sunrise Drive	-110	21740	0 2 /0-		S.A.	sices Indian
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heatth and Mental Hygiene. Important: If Itam 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examinating must be partitled at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Dyes 2 1 No If Yes, Give Year or Dates:	1 – 1955	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto F Specify:	cry Yes or No- lican, etc.)	Black, Whit	e, etc.
Maryland 21215-0036	ithin 72 ho ne. nen "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	(Give	DO NOT use retired	during most of working	9	b. Kind of Business	
22	illed w Hygier ther ti	S	12 17. Father's Name (First, Middle, Last)	Butche	er	18. Mother's Name		elf Emplo	yed
au	ld be ental ked o	То Ве	Hammond R. Working			Ruth R. S			
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rural			Zip Code)
	and 2 ealth m 27 i		Kristy Working-wife	13920	Sunrise	Drive Hag	erstown.	MD 21740	<u> </u>
Baltimore,	Pages 1 ient of H nt: If ite ry or ott		1A Buriai 2 Cremation 3 Li Removal from State		osition (Name of matory or other place L Cemeter	l	1/	c. Location - City or gerstown.	
Balti	permit. Depertm Imports eny inju		21. Signature of Funeral Service Licensee	22	2. Name and Addre	rn Blvd No	glas A.	Fiery Fun	eral Home
			23a. Part1. Enter the disease, or complications that caused the c shock, or heaf tailure. List only one cause on each line. Immediate Cause (Final						Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death) a. Due to (or as a con	sequence of):	aidio u	war 1	7		5915-
		iner	if any, leading to immediate Due to (or as a con	clerofo sequence of):	e Vasa	war 1	Wease		
90,	icate be executed physicien and s the burial-transit	l Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due y for as a con	equence of):	uud				
58760,		dical	d						
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	quires that n signed by	þ	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause giv	ven in Part I.		cco use contribute to	the cause of death?
Division of Vital Records,	The law requiresete has been sipage 2 should I	Completed					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Vita	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?		oth Oth	26. Place of Death	-		
o	Phys r this ral dir	5	27. Manner of Death 28a. Date of Injury	2 ER/Outpatier 28b. Time o	III JUA	4 Nursing non	ne 5 Besidence 8d. Describe how	be 6 ☐Other (Spe injury occurred	ocify)
ion	Attending ir death. actor: After by the fune	ation	1>	r) Injury		rk? Yes 2 □No			
Divis	ai or Atta s efter de: il Diracto d in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury : 4 building, etc. (Sp	At home, farm, streecify)	reet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
	To the Hospital or Attanding I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my 2 Medical Exeminer: On the basis of exam and manner stated.	knowledge, deat nination and/or in	th occurred at the tin	me, date and place, a opinion, death occurre	nd due to the caused at the time, date	se(s) and manner as a and place, and due	s stated. e to the cause(s)
)	To the comp	Σ	29b. Signature and title of certifier May E Wown W.		29c. Licens			Date signed (Moni	th, Day, Year)
0.	1				DZ38	2/2	16	11231	
8	+20		30. Name and address of person who completed cause of death wary E. Money, with a sisterar's S. 31. Date filed (Month 1977 1997) 4 2007 32. Sistrar's S.	(Item 23a) (Type,	DZ38	Hagers	town,	mD 21	780

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Katherine 1.52 pm Williams Vetober 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 X Months Days 67 Director 040-30-1498 2/20/40 Bowman, S.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Yes 2 No notified Directo Md. P.G. Landover 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r 20785 U.S.A. 1919 Belle Haven Drive # 204 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married African-1 ☐ Yes 2 ☑ No Specify ģ Hatherine altimore, Maryland 21215-003 72 hours 3 ₩ Widowed 4 Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Resident Manager Apartment Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eddie Void Maggie Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Williams/Son 1218 Farmingdale Ave., Capitol Heights, Md. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of HIMportant: If ite any Injury or ot **X**☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cem. 10/26/07 Clinton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc. 21. Signature of Funeral Service Licenses sall 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMONIA **Physician** 9 was disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MPHOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed physician and the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical as use IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day ed by the a detached for 5 Other (specify) P.O. has been signed by te 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, PNEUMONITI RADIATION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2□N0 ٩ 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral D 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0050951 10/20/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENILWORTH AVE # 2400 RIVERDALE MD20797

6166 31. Date filed (Month, Day, Year)
OCT 2 4 2007 6510 32. Registrar's Sign ture

			1 - For State Registrar	5	State of	Maryla		artmen rtificat			and M		giene Reg. No.	007	356	579
	Dhusisi	-	1. Decedent's Name (First, Middle	, Last)								2. Date of De Month	ath Day	Year	3. Time of	Death
	Physici /Medio		Juan Francis Wh	ite_								Octobe			1:15	P ^M
1	Examir	er	4a. Facility Name (If not institution	, give stre	eet and num	nber)		4b. City,	Town, or	Location of	of Death		4c. (County of Dea	ath	
			Shady Grove Adv	enti	st Ho			Rocky			0411			ntgomen		
Ю	Funeral		5. Social Security Number	6. Sex 1 🕮 M	2 F		. last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da	ıy, Year)		rthplace (State ountry)	
	Director		578-50-2848 Usual Residence of Decedent			7	0 '''					Aug. 6,	193	/ Ne	w Jerse	У
	land ow		10a. State 10b. County			10c. C	ity, Town or Lo	ocation							10d. Inside C	ity Limits
	Man	ţ	Maryland Montgo	marm		Dam	ascus								1 Tes	2 X No
	r 28s	lrec	10e. Street and Number	mery		Dani	abeas	10f. Zip	Code				10g. Citiz	en of What C	ountry?	
	7 wit	Funeral Director	10409 Maynard (ourt				208	372				USA			
	dead	ner	11. Marital Status		Was Dece Armed For	dent Ever in I	U.S. 13.	Was Dece	dent of Hi	ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		4. Race - Am Black, Whi	erican Indian,	
9	or Ite	E.	1 ☐ Never Married 2 🔀 Marr	bei	1 XYes If Yes, Giv	2 No		1 🗆 Yes		Specify:	1, 1 00110	1110411, 010.7		Specify:	110, 616.	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow he Medical Examiliar must be notified at	d by	3 Widowed 4 Divorced		Year or Da	ites:								Wh	ite	
5	nat adica	Completed	15. Deceden (Specify only higher	's Educat It grade c	ion <i>ompleted)</i>		16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa	ation during mos	t of worki	ng	16b. Kin	d of Business	s/Industry	
12	withir she.	g l	Elementary/Secondary (0-12)		College (1	-4or 5+))			ATTE	г / Сат		
d 2	Hygie ther ant,		17. Father's Name (First, Middle,	Last)	4		Admli	nistra	itor	18 Mothe	er's Name	(First, Middle	AT&		nmunicat	lons
an	ould be Mental Markad o) Be	Cornelius Franc		h.i.e									,		
Maryland	2 should be and Mental le marked (eumatic ev	၉	19a. Informant's Name/Relations				19b. Maili	na Address	(Street a			iola De al Route Numb			Zip Code)	
≥	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 ie markad other than "natural", or iteme 23e or 28e-f ehow other treumatic event, the Medical Examinational be natified at		Roseanne White,				6					amascus				
ē,	Health tem 27 othar tr		20a. Method of Disposition	WII		20b.	Place of Dispo					amas cus Date			r Town, State	
OL	ages ant of t: If i		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		noval from S	olato	cemetery, cre L1 Sou1			1	0/2/	/2007	Corm	antarm	, Maryl	and
Baltimore,	permit. Pages Depertment of the Important: If its eny injury or of once.	- 1	21. Signature Funeral Service			AJ									Funeral	
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			23a. Part1. Enter the disease, or	complica	tions that ca	used the dea								yrand	Approximat	te
	Physician	gi 7	shock or heart failure. List Immediate Cause (Final	only one	cause on ea	ach line.	, 4	boloms	0	44	1				Onset and	
	/Medical		disease or condition resulting in death)	a	Due to (or as a conse		7000		1000	//~	- Jun			30 mm	ites
	Examiner						4									
		Je.	Sequentially list conditions, if any, leading to immediate cause (Disease or injury) D. =	Due to (or as a conse	quence of):									
	cuted	Examiner	that initiated events	С.												
ó	e exe		resulting in death) Last		Due to (or as a conse	quence of):									
8760,	The law requires that the death certificate be executed tie hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical		d												
9	ing ph	Med	IF FEMALE:							-						
Вох	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c.		come of pregr rth 2 Pet		DEctopic pr	regnancy				2	3d. Date of de Month	•	Year
	t the dea by the al tached fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4☐Pregna 9☐Unkno	ant at time of	death 5	Other (sp	secify)					WORT	Day	r oa i
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Š,	signe bed	þ	Part II. Other significant condition	ATS COLLU	buting to de	ain but not re	isuling in the u	inderlying c	ause give	en in Part I.				No 3□P	to the cause of	Unknown
oro	w requir been si should	sted											163 2			
Records,	e law hes t	Completed										24a. Was auto	psy	prior to	utopsy findings completion of c	available ause of
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Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hoe	oital:				0		of Death	(Check only	опе)			
1 Inpatient 2 ER/Outpatient 3 DOA William 4 Nursing Home 5									ecify)							
n	ding l h. After funer	o	27. Manner of Death 1	3	(Monti	of Injury h, Day Year)	28b. Time of Injury	M	28c. Injury Work	γαι ∢? Yes 2.∐l		28d. Describe	now injury	occurred		
isi	Mtend death ctor: /	cat	2 ☐ Accident investing 3 ☐ Suicide 6 ☐ Could	not be	28e Place	of loiupy - At I	home, farm, st			165 2		28f Location (Straat and	Mumber or F	Rural Route Nun	nhor
Division	P # F C	Certification:	4 Homicide determ	ined	buildir	ig, etc. (Spec	eify)	reet, ractory	y, onice			City or To	wn, State)	TABINDO OF T	IDIAT FIODIO PUDI	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
_	To the Hospital of within 24 hours at To the Funeral D completely filled in		29a. Certifier 1 Certifyir	g Physic	ian: To the	best of my kn	nowledge deat	h occurred	at the tim	ne, date an	nd place	and due to the	Cause(s)	and manner a	is stated	
	e Ho.	Medical	(Check only 2 Medical one)	Examine	On the ba	isis of examin	ation and/or in	vestigation	, in my or	pinion, dea	th occurr	ed at the time,	date and	place, and du	e to the cause(5)
	Fo th Within Fo th	Me	29b. Signature and title of certifie					290	c. License	e number			29d. Date	signed (Mor	nth, Day, Year)	
	^-		> 55	~				17	000	574	55		Ootel	er Z	1, 200	7.
	11/1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)														
8	1		Sunil Saxena, M						e, R	Rockv	ille,	, Maryl	and			
à.	Sta	-	31. Date filed (Month, Day, Year) OCT 2 4													
	Registr	ar	OC1 2 4	ZUU	De	due.	N M									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Marlene Vernell White 2007 4c. County of Death Facility Name (If not justitution, give street and number, 4b. City, Town, or Location of Death Wisbure Medica /1/1comico Kegional enter 5. Social Security Number Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Sept. 6, 9. Birthplace (State or Foreign 6. Sex Days 1 □ M 2 🔀 F Months Hours Min. Maryland 220-52-8424 1949 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Maryland Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13200 Firehouse Road 21853 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **X**☐**N**O If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes XXNo Specify Specify: 3 Widowed 4 Divorced Black Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th laborer Perdue, Inc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benjamin Elsey Lovie Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alton L. White, Sr./husband 13200 Firehouse Road, Princess Anne, MD 21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul UMC Cemet. 10/30/2007 Mt. Vernon, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Sig utur of Fu JOLLEY MEMORIAL CHAPEL, P.A 21801 Approximate Interval Between Onset and Death Part1. Enter the disease, or complishock, or heart failure. List only or hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Immediate Cause (Final 2 hom disease or condition resulting in death) Due to (or as a consequence of): diselise wellrote Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

Items 23a or 28a-f show Iner must be notified at

"natural", or Iten dical Examiner

other than "natu

Item 27 is marke other traumatic

Important: If It any Injury or o

and 2 should be filed within 72 hours after د Health and Mental Hygiene. em 27 is marked

permit. Pages 1 and 2 should Department of Health and Men

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

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Examine

Completed by Physician/Medical

Medical Certification: To Be

29a. Certifier

burial-transi attending physician use as the for ed by the a detached f been signed by should be detact page

death certificate be executed

Division or Vital Records, P.O. Box 68760,

certificate funeral director, After

or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the f

1 Yes 2 No 9 Unknown	9 Unknown	
Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in I	Part I. 23e. Did tobacco use contribute to the cause of death?
dialetes,	melitis	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow
obshipie	lema	24a. Was an autopsy 24b. Were autopsy findings availab
chlared	Cardiony hattin	performed? death? 1
25. Was case referred to medical	26.	Place of Death (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 Other: 4	□ Nursing Home 5 □ Residence 6 □ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 □ Yes	28d. Describe how injury occurred
3 Suicide 6 Could not 4 Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. DIVISION ST. SALISBURY RODNEY WENRICH 1346

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

ct 22, 2007

State Registrar

31. Date filed (Month, OCT 2 istrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 07 WARDELL MARK WHITE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Peninsula Regional SALISBAM HICOMICO MEGICAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral XX** M 2□ F Days Months Director _12_0079 idence of Decedent 0079 MD 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County fshow iral", or items 23a or 28a-f shov Examiner must be notified at XXX 2 No Director MD SOMERSET PRINCESS ANNE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code VENTON ROAD 21853 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 □ No If Yes, Give Year or Dates: 1943–46 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify:BLACK Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. important: if Item 27 is marked other than any injury or other traumatic event, the Me CAMPBELL SOUP CO. Elementary/Secondary (0-12) College (1-4or 5+) LINE FOREMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BURDELL WHITE EMMA SHELTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VALENTINE WHITE DAUGHTER 28385 VENTON RD. PRINCESS ANNE, MD 21853 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
TRINITY UMC CEMETERY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-26-07 VENTON, MD 21. Signature ieral \$ 22. Name and Address of Facility BENNIE SMITH FUNERAL HOME 30479 PRINCE WILLIAM ST. PRINCESS ANNE, MD 21853 23a. Part1. Exshock, or er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sear failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consuquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): the burial Box 68760. attending physician for use as the buria the death certificate be Physician/Medical as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) ed by the a P.0. 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page performed certificate Division or Vital 2 No or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Oct 21,2007 VA 00064152 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar

CAPRIOLL ST

2007 Register's Signature

astre (m)

31. Date filed (Month, Day,

21801 SAlisbury Md

			For State		State of	of Maryl		epartme C <i>ertifica</i>				lental Hy	gien	e 200	7	35682
			Registrar 1. Decedent's Name (First	st. Middle. Las	(t)				110 07	Douin		2. Date of De		<u> </u>		3. Time of Death
	Physici /Medic		•	Connoll	•	Wesco	ре					Month Octobe	D.	ay 2007	ear	6:35 PM M
	Examir		4a. Facility Name (If not in	nstitution, give	street and nu	ımber)		4b. Cit	y, Town, o	r Location	of Death		4	c. County of	Death	
	3		Wicomico Nu						Salis					Lcomic		
- 8	Funeral Director		5. Social Security Number 139–12–1339	4	ex □M 2 T F	7. Age (In) 96	yrs. last birth Y	Month	ler 1 Year s Days	Hours	Min.	8. Date of Bin (Month, Did 10/7/1	ay, Yea	7)	Cour	lace (State or Foreign atry) Jersey
	pur ,		Usual Residence of Dece 10a. State 10b.	County		100	: City, Town	or Location			-				1	0d. Inside City Limits
	e Maryle a-f sho tified at	ctor		Wicomio	00		Salisb									1 X Yes 2 No
	or 28	Jire	10e. Street and Number						Zip Code				10g. C	itizen of Wh	at Cour	ntry?
	ath w	ra	900 Booth	St.					21801					USA		
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral Director	11. Marital Status 1 ☐ Never Married 2		If Yes, G	orces? 2 🔀 No ive	in U.S.		cedent of Hoecify Cuba 2 No	lispanic O an, Mexica Specify		ecify Yes or No Rican, etc.)	0-	14. Race - Black, Specify:	White,	
12 July 5 LUST Maryland 21215-0036	2 hours latural"; Ical Exa	Completed by	3 X Widowed 4 □ [Decedent's Ed	Year or I	Dates:	16a. E	ecedent's Us	sual Occur	ation		·	16b.	Kind of Busin		
213	ithin 7 se. nan "n	nple	Elementary/Secondary			(1-4or 5+)		Give kind of vife. DO NOT			st of work	ang			_	
42	ed wi	S	12		3		Re	gister	ed Nu					ealth	Care	9
and	d be fill antal H ced ott	B B	17. Father's Name (First, Thomas Coni									e (First, Middle Alpaug		n Surname)		
N.Y.	should Me mark mark	욘	19a. Informant's Name/F		Type. Print)		195. 1	Mailing Addre	ss (Street			ral Route Numb		or Town, St	ate, Zip	Code)
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Man altimore	ages 1 nt of H t; if Iter / or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cre	mation 3 🗆		Jale	Ob. Place of I cemetery					Date		Location - Ci	•	
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٥	di S	<u>۲</u>	1 Yes 2 No		1	Inpatient of Injury	2 ER/Outp		DOA	₩ N	lursing Ho	ome 5 Res		-		ý)
on	Attending r death. ector; After oy the funer	tion		Pending investigation	(Moi	nth, Day Yea	ar) Inj	ury M	28c. Injur Wor 1 □	k? Yes 2⊑]No	20d. Describe	11041111	dry occurred		
N N	after dea after dea Director	tifica		Could not be determined	28e. Plac	e of injury - /	At home, farn pec <i>ify)</i>	n, street, fact	ory, office	_		28f. Location	(Street a	and Number	or Rura	al Route Number,
	lospital o	Se			<u> </u>											
	T 4 T %	Medical Certification:	29a. Certifier 1 ☐ (Check only one) 2 ☐ 1	Medical Exan	niner: On the	e best of my basis of exar nner stated.	/ knowledge, mination and	death occurre or investigati	ed at the tillion, in my d	me, date a opinion, de	and place, eath occur	, and due to the rred at the time	, date a	s) and manr nd place, an	ner as s d due t	tated. o the cause(s)
_	To the within 2 To the comple	Me	29b. Signature and title o	of certifier	,			2	29c. Licens	e number			29d. D	ate signed (Month,	Day, Year)
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	10 mp		30. Name and address of			6			hore	Dr C	alich	oury MD	215	304	1	
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DHMH 17 Rev 1/2001

			Please	Type or Prin				-	_	
			For State Registrar	State of Ma		epartment of F Certificate of		Mental Hy	rgiene Reg. No.2 () () 7	35683
	Physici /Medic		1. Decedent's Name (First, Middle, La		HEL			2. Date of De Month Octobel	Day Year	3. Time of Death
Ì.	Examin		4a. Facility Name (If not institution, gi PANIASYVA AGJINIAL 5. Social Security Number 6.	ve street and number)	In/U/ (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	1	4c. County of Dea	•
	Director		213-10-7183 Usual Residence of Decedent 10a. State 10b. County	71	95 Y	rs.		Sept. 23		yland 10d. Inside City Limits
	he Maryla :8a-f shov otified at	Director	Maryland Somers		Toc. City, Town	Marior	Station			1 □ Yes 2 □XNo
	ath with t s 23a or 2 nust be n		10e. Street and Number 5549 Luther Mile				21838			SA
2-0030	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If the this and Mental Hygiene. It marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or Ne to Rican, etc.)		
7.12	ithin 72 h ne. nan "natu s Medi-al	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed) College (1-4or 5+	(Decedent's Usual Occup Give kind of work done life. DO NOT use retire	oation during most of wor d)	rking	16b. Kind of Business	/Industry
_	be filed within 7 tal Hygiene. d other than "r event, the Med	Be	17. Father's Name (First, Middle, Las	t)		Truck Driv		me (First, Middle	Freight , Maiden Surname)	
5	2 should be a and Mental is marked o raumatic eve	၉	Alfred Zeitschel 19a. Informant's Name/Relationship	(Time Print)	19h I	Mailing Addrass (Streat	Anne		per, City or Town, State,	Zin Code)
ě Č	1 and 2 s Health an tem 27 is i		Patricia E. Lohm 20a. Method of Disposition	, ,, ,	iter) 13	ll St. Fran	ncis Road			nd 21014
	t. Page rtment c rtant: if rjury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	fy)		Disposition (Name of crematory or other pla	rk Oct.	26, 2007	Glen Burni	e, Maryland
מ	permi Depar Impol any Ir	ļ	21. Signature of Funerah Service Lice Mary Beth Bra	dshaw-Pruit	tt	306 W. Mai	n Street	- Cris	& SONS FUNE field, Mary	land 21817
	Physician		Part1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition	nplications that caused to one cause on each line	he death. Do no Sep51-S	it enter the mode of dyi	ng, such as cardia	c or respiratory a	arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner	,	resulting in death) Sequentially list conditions.	b	consequence of					
ė	executed n and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of					
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<u>a</u>	death e atter d for u	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 Live birth 2 4 Pregnant at t	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	elivery Day Year
ecoras, r	requires that the een signed by the hould be detache	by	Part II. Other significant conditions	contributing to death but	not resulting in t		en in Part I.		tobacco use contribute t Yes 2□ No 3□ F	
Lec	The la	Completed	. Trend Jacton	٠.				24a. Was auto perf 1∐ Yes	s an 24b. Were a prior to death?	utopsy findings available completion of cause of
=	ysiciar s certii directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ⊿Inpatier	t 2∏ER/Outp	atient 3 DOA Oth	26. Place of Dea ner: 4 ☐ Nursing F		o <i>n</i> e) idence 6 □Other (Sp	ecify)
Sion or	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director; it	ation: T	27. Manner of Death 1	28a. Date of injury (Month, Day	28b. Ti	me of 28c. Inju			how injury occurred	carry
Š	ital or Att rs after de ral Directu led in by t	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	building, etc.	(Specify)	n, street, factory, office		City or To	(Street and Number or F wn, State)	
	the Hosp in 24 hou the Funer tpletely fil	ledical	(Check only 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of and manner stat	examination and	or investigation, in my	opinion, death occ	e, and due to the urred at the time	e cause(s) and manner a , date and place, and du	ue to the cause(s)
	with Con	Σ	29b. Signature and the of certifier	3 physica	ч	29c. Licens	59368		29d. Date signed (Mor	
16	68		30. Name and address of person who	100 6.6	creal c	ype Print-Schul	yMD	2180	7	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 4	2007 32. Registral	rs Signature	front	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Marv R. Alexander 4:38 P M 2007 Nov 6. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Futurecare Pineview Rehab Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 🏋 🕏 F 88 142 26 8728 South Carolina Director 1919 May 13. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 □Yes XXNo Director Maryland Prince George's Temple Hills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code than "natural", or Items 23a or he Medical Examiner must be n 20748 6006 Purdun Drive United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 [X] No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: **Black** 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien. Important: if Item 27 is marked other tha any injury or other traumatic exerthe Home Owner Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beulah Jowers Robert Gaskin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6006 Purdun Drive, Temple Hills, MD 20748 19a. Informant's Name/Relationship (Type. Print) Willie J. Alexander (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov 10, at 2007 20c. Location - City or Town, State 1 Purial 2 □ Cremation 3 □ Removal from State 4 □ Donation .5 □ Other (Specify) Camden, South Carolina 5 ☐ Other (Specify) Forest Lawn Cemetery eral Service Licensee 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d NO1391 Alexandria Ferry Road, Clinton, MD 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ANTERIOSCIENCE **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, burial physician Physician/Medical the attending p IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown been si Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy performe death? 1 ☐ Yes certificate 2 No 1☐ Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending | 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

State Registrar (Check only one)

30. Name and abo

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

<u>Philip Wisotsky,</u>

NOV 0

DHMH 17 Rev 1/2001

MD 12070 Old Line Centre, Waldorf, MD 32. Registrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)

MD

29c. License number

29d. Date signed (Month, Day, Year)

Z00

07-08617 Charles Alchin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 35685

	R	For State			Certifica	ate of	Death			- 1-		Reg. No.	-	10	Time of Death
Physician ledical Examine	/ 1	. Decedent's Name (First, Middle Charles	e,Last) Robe	ert		Alch	nin			2	. Date of De Month Novembe	Day er 6, 200			0150 hrs
	4	a. Facility Name (if not institution Gill Crest nursing hom		number)		41	c. City, Tov Towsor		ocation of		-	Ва	County of De Itimore C	Count	
Funeral	- (Social Security Number	6. Sex		yrs. last birl		If Under	Year Days	If Under Hours	24Hrs. Min.	8. Date of E			Coun	place (State or Foreign try) cyland
Director		213–36–6155	1X M 2		67	Yrs.			L	L	Squaii	Jer 2,	12-20	PICLE	yland
any		Jsual Residence of Decedent 0a. State 10b. County		100	. City, Town	or Location	on	-							0d. Inside City Limits
<u>*</u> ,	_	Maryland Balt	imore		Edge	mere									1 Yes 2 XNo
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the Maryla a or 28a-f.	Director	2121 Oak Road						219					SA		
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e : e	ᇍ		vorced If Yes, Give or Dates:		tod) 16a		Yes 2X 's Usual O			ind of wo	ork done		nd of Busin		
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imore, MD 2 Pages 1 and 2 shou nent of Health and I sant: If Hem 27 is n or other traumatic	- 1	Danille Alchin 20a, Method of Disposition	Dau	ghter	20b. Place	of Dispos	ition (Name	of cem			Date ember	20c. L	ocation - C		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		4 Homicide	Physician: To th	ecify)	knowled	dooth con	urred at the	time d	ate and n	lace and	due to the	cause(s) a	nd manner	as stat	ed.
he Ho in 24 he Fu pletel	ical	(Check only 1 Certifying one) 2 Medical Ex	Physician: To the k	e best of my asis of exam	ination and/	or investig	ation, in my	opinio	n, death c	ccurred	at the time,	date and pl	ace, and du	ue to th	ne cause(s)
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		30 Name and address of pers	on who completed	d cause of de	ath (Item 23	a)									
Ø		Theodore M. King, J		sistant Me			111 Pe	enn St	treet, B	altimor	e, MD 21	1201			
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29b. Signature and title of certifier O.C.M.E. November 2, 2007 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Sputhall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month) (Pann Year) 2007 32. Registrar's Signature	O. E at the c d by the stached	y Ph	Part II. Other significant cond	ditions contributing	g to death but no	t resulting in the	underlying	cause	given in Pa	art I.				
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			31. Date filed (Month) Pay Yo	7 2007 32	Registrar's Sign	atute	CARL!							

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene 35687 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 03^{Day}2007^{Year} **Physician** Nov. Kevin Maurice Alston 2:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner <u>Stella Maris Hospice</u> Baltimore Timonium 8. Date of Birth (Month, Day, Year) 04.21.1959 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Yrs. Director 523.92.2876 48 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code # B2 2206 Round Rd. 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 2 No Black Specify. þ Specify: 3 ☐ Widowed 4 Noivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Data Entry</u> Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lee Alston <u> Anna Beatrice Cra</u>wford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is Nathan Purdee/brother 55 Wottring Mill, Easton, PA 18042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 11.05.07 |Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee M01443 Due Retter Alternatives 8717 Green Pastures Dr. 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ACQUIRED IMMUNE DEFICIENCY SYNDROME disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to or as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? uneral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending investigation within 24 hours ofter death.

To the Funeral Orector: Af completely filled in by the United In Inc. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 7 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#9.17.18. perFH. G873.11/9/07 WS
State of Maryland 7 Department of Health and Mental Hygier 0 7 35688 State Registrar Amend 20b, perFH, g873, 11/7/07 TT Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 910 nomas dwara ,2007 lovember /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner trunda If Under 24 Hrs. 8. Date of Birth Convalescent + Repa CENTER 6 Year If Under 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 1 M 2 □ F Months Days -09-947 Yrs. Director MD Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City. Town or Location 10h County 28a-f show other traumatic event, it e Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò items 23a SONVILLE Roa Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours aftar 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 ₩Widowed 4 Divorced White "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Bethlehem 18. Mother's Name (First, Middle, Maiden Sumame)

Minnie K. Dietsch 17. Father's Name (First, Middle, Last Be Allen B Minnie ျှ UNKNOW! 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/035 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 Health item 27 i 20c. Location - City or Town, State CaughER Doroth 20a. Method of Disposition 20b. Place of Disposition (Name of Depertment of Important: If it any Injury or o cemetery, crematory 11 /7/2007 1 Burial 2 Cremation 3 Removal from State ⁴ □ Donation 5 □ Other (Specify) rematory altimore radley -21. Signature of Funeral Service Licensee 22. Name and Address of Facility ASKLON FUNCTAI 11272 ,2134 K 11cm DrINIS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final toula acclial **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Energy Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transit The law raquires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): ed by the attending physician adetached for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed bean 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hast certificate 1 ☐ Yes 2 ☐ Mo Hospital or Attending Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner' Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 20 ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the l 29b. Signature and titl of certifier 29c. License number 29d. Date signed (Month, Day, Year) -06-07 D57028 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Ridgel M.D Avenue Annapolis MD Aditya Chipra 31. Date filed (Month, Day, Year) 1000 #231 2. Registrar's Signature State marks. 7 2007 0 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2007 Year NOV. Michael Altmeyer 4 7:25a M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 918 Orems Road Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months N 2 □ F 217-18-5113 84 Aug.1,1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD 1 ☐ Yes 2 No Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 918 Orems Road 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No 1 ☐ Yes 2 No Specify: White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Beth Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Altmeyer Katherine Shultz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Myers /niece 36 Walkern Road Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Cemetery 11/8/07 Baltimore MD 21. Signature of Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ONGESTIVE HEARS disease or condition resulting in death) Due to (or as a consequence of) SCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to deat, but not resulting in the underlying cause given in P 📶 I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Was a... autopsy performed? Yes 2 No 1∐ Yes 26. Place of Death (Check only one) No Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury

Physician /Medical **Examiner** be executed

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

death.

burial-transi the as for use

Exami attending physician Physician/Medical signed by the a d be detached f ģ page 2 should Completed director, Be this funeral c Certification: To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu

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OF	18/			A	3:

Was case referred to medical examiner? 1 🗌 Yes

Manner of Death Natural 2 Accident

3 ☐ Suicide 4 Homicide

(Check only one)

29b. Signature and title

29a. Certifier

6 Could not be determined

and manner stated.

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

D18326

license number 29d. Date signed (Month, Day, Year) Nov. 6, 2007

CHR, Baltimore, MD, 2122/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NACCM GAUHAR (SSEX Modica

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001 07-08379 Liliana Plata Behm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 3	3569	
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		For State		Certi	ficate of i	Death		I o Data of	Reg. No		3 Tim	e of Death
Physician	n/ 1.	Decedent's Name (First, Midd	lle,Last) Liliana Plata-Rehm	Plata Bel					Day er 27, 20	Year 007	23	35 hrs
	4:	a. Facility Name (if not institution		ber)	41	b. City, Town, or Temple Hil		Death		Prince Ge		
	8	3035 Brinkley Road	Apt. 101		11:45-4	If Under 1 Yes		24Hrs 8 Date	of Birth(MN	N/DD/YYYY)	9. Birthplace	(State or
Funeral Director	: 5	. Social Security Number		. Age (In yrs. lasi	t birthday) Yrs.	Months Day			8/198		-oreian	Mexico
	U	Isual Residence of Decedent									10d. 1	nside City Limits
auò	- 1	0a. State 10b. County			own or Location						1	Yes 2 X No
nd Show	<u>►</u> M	Maryland Princ	ce George's		Temple	e Hills			10a C	itizen of Wha		
faryla	Director	0e. Street and Number				10f. Zip Code			109.0			
the N		3035 Brinkley				2074	48	in? (Specify Yes	or No-	Mex:	American In	dian, Black,
ms 23	eral	1. Marital Status Never Married 2 X		dent Ever in U.S ces?	3. Was	s Decedent of F es, specify Cuba	an, Mexican,	Puerto Rican, etc	:.)	White,		
or ite	.≂ I		1 Yes Divorced If Yes, Give Year	2 X No	1\X	Yes 2 N	lo specify:	Mexican		Specify:	Hispa	nic
5-UU.30 do within 72 hours after death with the Maryland lygene. other than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once.		Widowed 4 D 15. Decedent's Education (Sp	or Dates		16a Deceden	t's Usual Occur	ation (Give I	kind of work done	16b	. Kind of Bus	iness/Indust	у
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hin 72 e. than	ple	,	1			House				Own I		
Z1Z13-0030 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	하	17. Father's Name (First, Middl	le, Last)					's Name (First, M				
LILI uld be fill Mental H marked c event, t	Be	Louis Plata			Lagh Mailin	- Addross (St		nber or Rural Rou			n, State, Zip	Code)
AID 21219-UU30 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relation						, Apt. 10				
2 2 2 2 2	L	Joshua C. Beł	nm/Husband		Place of Dispos	sition (Name of		Date	20	c. Location -	City or Town	, State
Ore, es l ai of He If ite		1 Burial 2 X Cremati	ion 3 Removal fro		crematory or ot Cremator			November	1. 20)7 CI	inton,	MD
Baltimore, permit. Pages I au Department of Hee Important: If ite		4 Donation 5 Other	Specify;			-	ess of Facilit		1, 40	,, or	III.CAI,	
Baltimo permit. Page Department of Important: injury or oth	1.4	Z. Sign ur of Funeral S i	W IIMn/	/		Name and Addr Funera	1 ~~~~	io Formy D	nad C	linton_	MD 207	35
		23a. Fari L. Epiter the Use As 2	or complications that ca	aused the death.	. Do not enter	the mode of dyi	ng, such as	cardiac or respira	ory arrest,	shock, or he	art Ar	etween Onset an
Physician 'ledical		failure. List only one cau	use on each line.									Death
.aminer		Immediate Cause (Final diseasor con whon resulting in death		consequence o								
		Sequentially list conditions,	b		£).							
	Examiner	if any, leading to immediate cause. Enter Underlying Cau	use	consequence o	iτ):							
/	a	(Disease or injury that initiate events resulting in death) La	d Due to (or as a	consequence o	of):							
cecuted n and - transit			d									
760, cate be execute physician and he burial - trat	/Medical	UNPENDED	X AMENDED,	perME,g87	3 <u>, 11/9/</u>	07 TT				23d. Date o	f delivery	
	/Me	IF FEMALE: 23b. Was decedent pregnant i		outcome of preg birth		etal death	3 Ector	oic pregnancy		Month	Day	Year
Sox 68 leath certifing e attending for use as	sician	past 12 months?	4 Pregi	nant at time of de	eath 5	Other (Specify)						
Boy death the att	Physi	1 Yes 2 No 9			let a to . Alan	- underlying car	re given in	Part I 23	e. Did toba	acco use conf	tribute to the	cause of death?
F.O. Be ires that the de signed by the d be detached f	by PI	Part II. Other significant cor	nditions contributing t	to death but not i	resulting in the	e underlying cat	ise given iii					y 4 Unknow
ires the signed abe d	d b								a. Was an	24b.	Were autop	sy findings availa
cords, law require has been si) je							 .	autopsy perform	ed?	death?	pletion of cause
ecol he law ate has	Completed								Yes 2	No	1 Yes	2 No
of Vital Recing Physician: The After this certificate Queerly age	BeC	25. Was case referred to me examiner?			7		Other Of Dea	th (Check only on Nursing Hom		esidence 6	✓ Other: S	cene
Vita hysici this c	To E	1 ✓ Yes 2 No		Inpatient 2	ER/Outpatie		. Injury at We	ork? 28d. [escribe ho	w injury occu		
ing Pl	i.	27. Manner of Death 1 Natural 5	Oct 197	e of Injury th, Day Year) , 2007	2324 hrs	1	Yes 2	— ISubie	ect shot	self		
Division of Vital Records, P.O. To the Inospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by commenced grided in by the funeral director, as 2 should be detector.	Certification:	Natural 5 2 Accident	Pending	ace of Injury - At	home farm si	treet factory of			ocation (St	reet and Num	ber or Rural	Route Number,
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	iii	3 ✓ Suicide 6	Could not be	y) Multi-Fam				3035	r Town, Sta Brinkley F	Road, Temp	ole Hills, MI	
Divis Hospital or / 24 hours after Funeral Dire	S		, (-, -, -, -, -, -, -, -, -, -, -, -, -, -	- t of my language	dae death oc	curred at the tin	ne, date and	place, and due to	the cause	(s) and mann	er as stated	
he Ho in 24 he Fu	ical	(Check only one) 2 ✓ Medical	I Examiner: On the basis	s of examination	and/or investi	igation, in my or	oinion, death	occurred at the ti	me, date a	ne place, and		
To the within To the	Medical	29b. Signature and title of co	and manner ertifier	stated		29c. L	icense numb	per		29d. Date si		i, Day, Year)
(3)	-	1	winout.	IMID.			D.C.M.E.			October :	28, 2007	
		30. Name and address of pe		ause of death (Ite	em 23a)							
0		Donna M. Vincent	ti, MD Assistant	Medical Exa	aminer 1	I11 Penn St	reet, Balt	imore, MD 21	201			
Reg	State	1101	Y 2007 32.	negistrar s Signi	A D	news F						
OHMH 17 Rev			DCME	The second secon	ORIGH	NAL						

		1	For State Registrar	State of Maryland /		t of Health and e of Death	Mental Hyg	giene neg. No2 0 0 7	35691
9			1. Decedent's Name (First, Middle, Last)	D 1			2. Date of Dea Month Nov 2,	Day Year	3. Time of Death 1:00 PM
	Physicia /Medic	ai		eanne Beck	4h City	Town, or Location of Dea		4c. County of Dea	
	Examin	er '	4a. Facility Name (If not institution, give si 10515 Cedarville			andywine		Prince Ge	_
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last b	Yrs. If Under Months	1 Year If Under 24 Hr Days Hours Mir			nthplace (State or Foreign Country) rginia
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
	Maryla f sho	-	Maryland Prince Geo	orge's	Brandywi	ne			1 Yes 2 No
	or 28a	Directo	10e. Street and Number	D 1 10 11	10f. Zip			10g. Citizen of What C	•
	ath wi		10515 Cedarvil	Le Koad #Z-II 2. Was Decedent Ever in U.S.		0613 dent of Hispanic Origin?	Specify Yes or No	United Sta	
30	be filed within 72 hours after death with the Maryland at Hygiene. Id Hygiene than "natural", or Itama 23a or 28a-f show of other than "natural", or Itama 20a or 28a-f show event, I're Medical Evariation must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Trovorced	Armed Forces? 1 Yes 277No If Yes, Give AA Year or Dates:	If Yes, spe	city Cuban, Mexican, Pue	erto Rican, etc.)	Black, Wh	White
Maryland 21215-0036	2 hou	ted	15. Decedent's Educ (Specify only highest grade		ia. Decedent's Usu (Give kind of wo	al Occupation ork done during most of w	vorking	16b. Kind of Busines	s/industry
71	ithin 7 ne. han °r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Secretar	se retired)		Us Cens	us
ב ס	filed w Hygiei ther th	CO	17. Father's Name (First, Middle, Last)				ame (First, Middle,	Maiden Sumame)	
an		To Be	Charles Wood				ry Pruitt		
ary	2 shot and N is me		19a. Informant's Name/Relationship (Ty)			s (Street and Number or			
e, N	1 and Health em 27 ther tr	i	Deborah Jean. Bed	20b, Place	of Disposition (Na	nolia Park	Place, C.	Larksburg . 20c. Location - City	
nor	ages ant of nt: if it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	tery, crematory or r. Hill Co	emetery Nov	10 2007	Suitland	MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked eny injury or other traumatic e <u>once</u> .		21. Signature de Ameral Service Coense		22. Name a	nd Address of Facility	e Funeral	l Home,Inc	6633 01d
m —	88 2 8		- John Might		Alexar	ndria Ferry	Road, C1	inton, MD	20735 Approximate
) is	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Myound	al Into	Noturn	ac or respiratory a		Interval Between Onset and Death
8	/Medical Examiner		1	Due to (or as a consequence	1 Mel	itus			
ļ		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	ce of):				
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):				
8760,	ate be executed obysicien and the burial-transit			DB6 (0 (0) as a consoder	30 317.				
9	ificate g phys as the	edic		1.					
Вох	attendin for use	Physician/Medical	in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3 □Ectopic			23d. Date of Month	delivery Day Year
P.O.	t the d	hysic	1 U Yes 2 XNo 9 Unknown	9 Unknown					
	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions co	ntributing to death but not resultin	g in the underlying	cause given in Part I.			e to the cause of death? Probably 4
Vital Records,	The law reste has bee pege 2 sho	Completed					24a. Was auto perf 1 Yes		
ital	entifice	Be C	25. Was case referred to medical examiner?		(2007)		Death Check on	one	
of <	Physician: rthis certific ral director,	ို	1 ☐ Yes 2 ☑ No 27. Manner of Death		Outpatient 3 [3 VV	how injury occurred	Specify)
on	Attending In death.	tion	1 Staturaf 5 Pending 2 Accident investigation	(Month, Day Year)	In _f ury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No			
Division	i or Atten after dea Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, facto	ory, office		(Street and Number of own, State)	r Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai C	29a. Certifier 12 Certifying Phyone) 2 Medical Exam	sician: To the best of my knowle iner: On the basis of examination and manner stated.	dge, death occurre a and/or investigation	ed at the time, date and pon, in my opinion, death o	lace, and due to the occurred at the time	, date and place, and	due to the cause(s)
	To the within To the complex	Me	29b. Signature and title of certifier	120	2	9c. License number		29d. Date signed (M	fonth, Day, Year)
			> Hum Edge	eembe My		P23826		11/5/0	+
	(a		30. Name and address of person who c			, B201 C	linton 1	MD 20735	
8	St	ate	Glenn Edgecon	mbe MD 7700 01	a Branch	Ave,		W 60133	
1	Regist	rar	NOV 0.7	UU/ A MESTER Suit Su	L. Balling				

	1	For State Registrar		State	of Ma	aryland			nt of H ate of L			ental Hy		e .200	7	35692
Physician		1. Decedent's Name (First, M		Barnes								2. Date of De Month Novem	ath			3. Time of Death 9:00pm M
/Medical Examiner	- 10	ta. Facility Name (If not insti Carroll Hosp	ution, gi	ve street and n				4b. Ci	y, Town, or West	Location mins				c. County of I		
Funeral Director		5. Social Security Number 218–38–4627		Sex 1 □ M 2 1 F	7. Age	e (In yrs. la	ast birthda Yrs.	y) If Und Month	ler 1 Year s Days	If Under Hours	Min.	8. Date of Bir (Month, Da July 2.	th ay, Yea/ 5,]	939	Birthp Coun	lace (State or Foreign NC
Maryland -f show led at		Usual Residence of Deceder 10a. State 10b. Co	unty	rroll		10c. City	, Town or	Location	Wes	tmin	ster				1	0d. Inside City Limits 1 ☐ Yes 2 No
ifter death with the Mar r Items 23a or 28a-f si liner must be notified Fineral Director		10e. Street and Number 3773 Nichol	son	Road				10f. 2	Zip Code	157			10g. C	itizen of Wha		itry?
urs after dea al", or Items examiner mu		11. Marital Status 1 □ Never Married 2 □ 3 □ Widowed 4 □ Divo		12. Was De Armed F 1 Yes If Yes, O Year or	Forces? 2□XN Sive		S. 1		cedent of Hopecify Cuba	ispanic Or an, Mexica Specify		ecify Yes or No Rican, etc.))-	14. Race Black, \ Specify:		etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heatlth and Mental Hygiene. Important: If them 27 is marked other than "netural" or items 23a or 28a-f show eny injury or other traumatic event, the Medicel Examiner must be notified at once. To Re Commisted by Finneral Director		15. Dec	edent's E	Education rade completed		+)	(Gi life	ve kind of DO NOT		ation during mos	st of worki	ng		Kind of Busin		dustry
would be filed w Mental Hygie arked other tl atic event, th	1	11 17. Father's Name (<i>First, Mi</i> Joseph Ha		•			НО	memak	er			(First, Middle rna Ho	, Maide		LC	
alth and M 27 is mar rraumati		19a. Informant's Name/Rela			Spou	se)						al Route Numb				
Pages 1 ament of Heant: If Item		20a. Method of Disposition 1 ∏ Burial 2 □ Crema 4 □ Donation 5 □ Oth			n State				lame of or other place em. Ga		s 11/	7/07		Location - Cit nksbur:		
permit. Deperting porting porting eny Inj		21. Signature of Funeral Se	L	Ha	igh	1		Pang Haigh Sykes	and Addre	ss of Facil eral , MD	Home 2178	& Cha 4 (41	pe1 0)-	P.A. 795-140	(Bo	ox 195)
Physician /Medical Examiner		23a. Part1. Enter the disear shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	(_a W	1e+.	the death ne. a consequ	di e	enter the m	Tes =	fh-e	as cardiac d	or respiratory a	arrest,			Approximate Interval Between Onset and Death
ificate be executed 3 physician and as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	c		a consequ										
Attending Physician: The law requires that the death certificate that the death certificate that been signed by the attending by the funeral director, page 2 should be detached for use as fifeation. To Be Completed by Dhysician Medical Completed by Dhysician Medical Completed by Dhysician Medical Completed by Dhysician Medical Completed by Dhysician Medical Completed by Dhysician Medical Completed by Dhysician Medical Completed by	1	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			e birth gnant at	pf pregna 2 ☐ Fetal time of de	death	3 □Ectopi 5 □ Other	pregnancy (specify)	/				23d. Date o Month		ery Day Year
quires that in signed build be deta	2	Part II. Other significant co	nditions	contributing to	death b	ut not resu	ulting in the	underlyin	g cause giv	en in Part	t I.					the cause of death?
: The law requi	The state of the s											24a. Was auto per 1 Yes	opsy formed?	24b. We pride dea	ere auto or to co ath?]Yes	opsy findings available ompletion of cause of 2 ☐ No
Physician: The this certificate al director, pag	3	25. Was case referred to m examiner? 1 Yes 2 No	edical	_	Inpatie		ER/Outpa		DOA Oth	er: 4 🗆 N	Nursing Ho		sidence			ity) HOSpice
To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		2 Accident in 3 Suicide 6 □ C	ending vestigati ould not etermine	on	onth, Daj	y Year)	28b. Tim Injui	y M	28c. Injui Wor 1 [] tory, office	yat k? Yes 2[□No	28d. Describe 28f. Location City or To	(Street	and Number		ral Route Number,
o the Hospitel of the The The The The The The The The The T					basis o	f examina										stated. to the cause(s)
To the within 2 To the comple		29b. Signature and title of control of the second of the s	ertifier	and ma	anner sta	ated.	10		29c. Licens	e number	2 g Z		29d. I	Date signed	Month,	Day, Year)
12		30. Name and address of p	rson wh	o completed ca	use of d	leath (Item	23a) (Ty	pe, Print)	y,ne	ار ا	C+-	f 1	D,	Re.,	f	, fan M
State Registra		31. Date filed (Month, Day,	Year)	2007	Registr	ar's Signa	erre	33456	F							2/131

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 pm of ward 12 partinent of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** John Bucinstas 02 Nov. 2007 2:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Parkton
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) 20784 Old York Road Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 212.30.5036 92 07.26.1915 Director Lithuania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State show r 28a-f show notified at 1 ☐ Yes 2 No Director MD Baltimore Parkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code rms 23a or 7 20784 Old York Road 21120 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner ma Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Architect Architectual Firm 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Is marked ot Anastazi ja Anastăzila Augustauskaite <u>Viktoras Bucinskas</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vida Bucinskas-Bichell of Health a litem 27 ls Old York Road Parkton, MD 21120 tion (Name of Date Date Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of I Important: If its any Injury or of once. 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) Nov.5,2007 Beltsville, MD 22. Name and Address of Facility Cremation And Fueral Balto 21. Signature of Funeral Service Licensee Alternatives 8717 Green Pastures Dr. MD M01443 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): 20+ yem /Medical Examiner 20+yans COVONOVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit The law requires that the death certificate be execu Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 24a. Was an s certificate has b lirector, page 2 s performe 2 No 1□ Yes Fo the Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Injury 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 29a, Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) nte of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 11/5/07 04037 30. Name and address of perso who completed cause of death (Item 23a) (Type, Print) DiHarnia 4000 OLD CUNT PLD BALTIMONE, MD taplan. 10 22. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 7 2007 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere Of Certificate of Death

								Cer	uncat	e oi	Dealli			Reg. No.			
			1. Decedent's Nam	e (First, Midd	le, Last)								2. Data of D Month	eath Day	Yaar	3. Tima	a of Death
	Physicia		Donald						Bai	lev	Jr.		1 1	02	2007	111:	30am
	/Medic		4a Facility Name (If not institution	n nive street an	d number)						wn, or Lo	ocation of Dea		y of Deeth		Joan
4	Examine	er	402 Ove		_						Car	tons	sville		Balt	imor	'e
								-4 6 2-4	If Undar	1 Vaar		24 Hrs.					
	Funeral	- 1	5. Social Sacurity N		6. Sax 1 XM 2		је (In yrs. la	St birthday) Yrs.	Months		Hours	Min.	(Month, E		9. Birth		te or Foreign
	Director		218-82-0				47	115.					07 2	0 60		MI)
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	tha Me 28a-1 s notifies	횼ㅣ	MD	Balti	more			Cato	nsvı	тте							as zigito
	1 5 E	<u>ē</u>	10e. Street and Nu	mbar					10f. Zip	Coda				10g. Citizan of	What Cou	ntry?	
	eftar daath with the Meryle or Herne 23e or 28e-f sho miner must be notified at	9	402 Ove	arhroc	k Poac	4				2	1228			U.	S.A.		
	Jaati Jaati	9	11. Marital Status	FLDLOC	12. Was	Decedant	Evar in U,S	. 13. V	Vas Deced			igin? (Sp	ecify Yas or N Rican, atc.)		ce - Amari		
	ftar daa fterna free.m	اق	1 Naver Marr	ied 2□ Mar		ad Forcas? Yas 2 ☑ I s, Give**							Hican, atc.)	Bl	ack, White,	atc.	
ဗ္ဗ	filed within 72 hours effar death with the Meryland Hygiene. ther then "natural", or fleme 23a or 28e-f show mt, the Medical Examiner must be notified at	Be Completed by Funeral Director	3 🗆 Widowad	4X Divorced	lf Ŷe Yaai	s, Give** or Dates:		1	☐ Yas	X [□] No	Specify:	•		Spec	^{ђу:} В1	ack	
ŏ	hor hor	8		15. Deceder	nt's Education			16a. Deced	lant's Usua	al Occur	oation			16b. Kind of	Business/In	dustry	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James Edward Butler, Sr. October 2007 2144 p ^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A St. Agnes Hospital Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 4 2 F Yrs Director Maryland 218-26-5652 75 May 16, 1932 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County works. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 □Xes 2 □ No Director Baltimore N/A Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 527 Coventry Road 21229 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □ Yes 2 □ **N**o Specify: Completed by Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Baltimore City Housing** Maintenance Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Butler Lillie Butler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elva R. Butler Wife 527 Coventry Road Baltimore, Maryland 21229 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Kurial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) 11/07/07 Garrison Forest Veterans Cemetery 733775 22. Name and Address of Facility 21. Signature of Funeral Service License Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 estain tot 23a. Part 1. Enje the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY EMBOLISM **Physician** Hour /Medical Due to (or as a consequence of) Examiner DEEP VENOUS THROMBOSIS Weeks Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) physician Physician/Medical as Box IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a P.O. 9 Unknown signed to be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Hypertension, Hyperlipidemia 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2∏ No Vital Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 9 this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospital or Attending 5 Pending investigation **1** ○ Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D0037359 November 1, 2007 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Jeffrey L. Seibel, M.D., Ph.D. 900 Caton Avenue Baltimore, MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

JAMES

			For State	State of Ma	arylan	•	artment rtificate			Mental H	ygiene	ອ າກ	07	355	96
			Registrar 1. Decedent's Name (First, Middle	, Last)		061	lincale	OI De		2. Date of	Death			3. Time of D	
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	Examin	_	4a. Facility Name (If not institution Saint Jose)	, give street and number) oh Medical	Cen	iter	4b. City, To	own, or Lo	cation of Deat		40	. County	Palti	more	
	Funeral Director		5. Social Security Number 212–56–7999	6. Sex 7. Ag	e (In yrs. i	last birthday) Yrs.	If Under 1 Months		Under 24 Hrs Hours Min	(Month,	Birth Day, Year 28–194		9. Birthplac Country	e (State or Md.	Foreign
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	ss 1 and 2 of Health Item 27 I		Dorothy Bowman	Mother Mother	20h B				Street	Apt. Date			timore - City or Towr		2121
annore,	Se to L		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S _i		i	Place of Dispo emetery, crea It. Zic			11	-10-07			owne, 1		
gall	permit. Page Department Important: if any injury o		21. Signature of Funeral Service	Licensee			2. Name and	Address	of Facility	March e., Bal	F.H.	Easi	t	1202	
ı	۶		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the deatl	h. Do not en							A	pproximate iterval Betw	veen
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8/00,	ficate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):									
20	ficate the physical p	dical		d											
J. BOX	sath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗆 Feta	Ideath 3	⊒Ectopic pre ⊒ Other (spe				_		ate of delivery lonth D		ear
л. О.	w requires that the deben signed by the should be detached	, Ph	Part II. Other significant condition	ons contributing to death b	out not res	ulting in the u	ınderlying cau	use given	in Part I.	23e. D	id tobacco	use con	ntribute to the	cause of de	eath?
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ō	ding Physician: The h. After this certificate ha funeral director, page	7: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inj	ury	28b. Time o		c. Injury a Work?	4 Nursing	Home 5 ☐ R 28d. Descri					
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, it	Medical C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the best Examiner: On the basis of and manner s	of examina	owledge, deat ation and/or in	th occurred a ovestigation,	it the time, in my opir	date and planion, death oc	ce, and due to curred at the ti	the cause me, date a	(s) and mand place	nanner as state, and due to t	ed. he cause(s))
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	3		30. Name and address of person	who completed cause of	death (Iten								L 2 M Ph L 21	main :	-, 4 ,,
	Sta	te	JOGINDER F' 31. Date filed (Month, Day, Year)	MEHTA M. I 32. Regist					DRIVE	<u> </u>	OWSO	N,	MARYLI	HND E	2120
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2007 **Physician** 8:45 P November 1, homas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Parkville, MD 21234 Baltimore 0akcrest If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 10-3-1913 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** 216-01-4809 1 XM 2 □ F Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyghene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 No Director Parkville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 Funeral 8820 Walther Blvd Apt. 4012 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black White etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 12 Firefighter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Bradlev Frances Welsh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 66 Barrington Place Bel Air, MD 21014 Bob Bradley (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 □Removal from State Marylana. Bayview Crematory 1114/07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9706 Belair Road Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequent Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4□Pregnant at time of death 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 hknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2, 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: ၉ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 🗌 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

attending physician and for use as the burial-tran OndS ト・G Poclaソーロ signed by the a cate has t page 2 s certificate the Hospital or Attending Physician: director, After this funeral within 24 hours area with To the Funeral Director; Aff

altimore, Maryland 21215-0036

State Registrar 29a. Certifier (Check only

29b. Signature and title of certifier

Name and address of person who completed cause of death (item 23a) (Types F 2200 M Registrar's Signature 31. Date filed (Month, Day, Year) Ö

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER 6 2007 LEWIS METZLER BURDETTE 11:00 A M /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FOREST HILL HEALTH & REHABILITATION HARFORD FOREST HILL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Days Hours M 2□ F 73 215-30-5897 Apr. 13, 1934 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Cecil Port Deposit 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21904 18 Maple Hill Drive Funeral Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any Injury or other traumatic event, the Medione. Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Mabel Jeffers ပ Archibald Harry Burdette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18 Maple Hill Drive, Port Deposit, Maryland 21904 Brenda B. Warehime / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 11-7-07 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature A Funeral Service Licenses 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician fulline TOTARIOC /Medical Due to (or as a consequence of): Examiner cerchant Sequentially list conditions Due to for as a consequence of Examiner It any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and as the burial-trar Due to (or as a consequence of): Box 68760. attending physician pe Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 : has certificate 2 🗀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Oj

State 31. Date filed (Month, Day, Year)
Registrar NOV 0 7



DR. DAVID DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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November 6. 200 +

			For State Registrar	State of	Marylan		artment of H tificate of L		d Mental Hyg	jiene lag. No.2 0	07	35700
			Decedent's Name (First, Middle, Li	ast)		·			2. Date of Dea		Vana	3. Time of Death
П	Physici /Medic		DEWEY HOOD	BOWMAN					NOVEMBE	ER 6, 2	007	5:10 A M
Service .	Examin		4a. Facility Name (If not institution, gi	ve street and numb	ber)		4b. City, Town, or	Location of De	eath	4c. County	of Death	
			Sunshine Acre	es Assist	ed Liv	ing	White Ha	11		Harf	ord	
	Funeral			Sex 7 1 □ M 2 □XF	. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 H	lin. (Month, Day	, Year)	Coui	
	Director		217-18-1805 Usuel Residence of Decedent		80)			May 24,	1927	Mar	yland
	yland		10a. State 10b. County	-	10c. City	, Town or Lo	cation				1	10d. Inside City Limits
	Marie 1	Director	Maryland Harford		Chu	rchvi]	le					1 Yes 2 No
	or 28	Oire	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?
	23a		637 Priestford	-			21028			USA		
	er de	Funerai	11. Marital Status	12. Was Deced	es?		Was Decedent of Hi f Yes, specify Cuba		? (Specify Yes or No- uerto Rican, etc.)		ce - Amen ck, White,	can Indian, , etc.
36	be filed within 72 hours atter deeth with the Maryland tal Hyglene. d other than "natural", or Itams 23e or 28e-f show avent, the Medical Exaction must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Styles 2 If Yes, Give Year or Dat	es:		I□Yes 2∏XNo	Specify:		Specif	y: W	hite
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	1 and Health Ism 27 other tr		Valerie Bowman H 20a. Method of Disposition	Opkins /	20b. P	tace of Dispo	sition (Name of		ed, Church	20c. Location		
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altimore,	그 등 후 중		21. Signature of Funeral Sorvice Lice		Bel		Memorial (Home, P.A.	Bel Air	, IVE	rytano
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ı	Physician		Immediate Cause (Final disease or condition	F	1 51	risko	Dones	tio				Onset and Death
1	/Medical		resulting in death)	Due to (o	r as a consequ	uence of):	- ye	/				0
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9	tificat ig phy as th	ledi										
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<u>.</u>	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be deteched for use as the burial-transit	Completed by Physician/Me	in the past 12 months? 1 Yes 2 No		nt at time of d		Other (specify)	, <u> </u>		M	onth	Day Year
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	ysicle s cer	0 0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 □ In	patient 2	ER/Outpatier	at 3 DOA Othe		ng Home 5 ☐ Resid		her (Spec	ify)
0	ig Physiter this	T :u	27. Manner of Peath	28a. Date of	Injury , Day Year)	28b. Time o			28d. Describe h			
Ö	endin sath. or: At	atio	1 Natural 5 Pending investigate	on	, 24, 7, 04.7	,		Yes 2 □ No				
Division of	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place	of Injury - At ho g, etc. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (S City or Tox		ber or Rur	ral Route Number,
	pital ours a erel C		29a. Certifier 1 Certifying	(C)				- data and a	less and due to the			
	24 ho Fun etely	Medical	(Check only one)	invinar: On the bas	sis of examina	tion and/or in	vestigation, in my o	pinion, death o	lace, and due to the occurred at the time,	date and place,	, and due	to the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certains	/			29c. Licenso	e number		9d. Date signe	ed (Month	, Day, Year)
	·		27/26	200	FACO		#3	902	2 1	Drenn	Son	6 2007
	NXI		30. Name and address of person, wh	completed cause	of death (Item	n 23a) (Type,	Priot)	~	/ / M	7	19-	<u> </u>
	1		Veten Latresti	70,13	087as	91499	enkillo	y tolg	reword /1/4	1 40	10.	
	Sta		31. Date filed (Month, Day, Year)		gistrar's Signa	iture	N. 0					
	Registr	ar	NOV 0 7 20	JI Allando	Car St.	AN CON	S. C. A.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AND TIEM 8 per H, 873 11/7/07 WS.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 11:55 A M ZINAIDA NOVEMBER 2007 BOLOTINA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 06/21910 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ₩ F **-6/24/1919**UKRAINE 589-33-2176 88 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County items 23a or 28a-f show notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Examiner must be 4411 SILVERBROOK LANE UNIT H-303 U.S.A. 21117 death v Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: natural", or 1 ☐ Yes 2 🛣 No WHITE Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int; if Item 27 is marked other than BIOCHEMIST SCIENCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LAZAR BOLOTIN **ESTHER** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important; if Item 27 is
any Injury or other trau VITALY KRONER / SON 4411 SILVERBROOK LANE UNIT H-303 - OWINGS MILLS, MD 20c. Location 1 Git or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition ARLINGT ON CHIZOR Place 11/04/2007 1 XBurial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) AMUNO CONG. 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS.. INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onsetland Death 23a. Part1. Enter the disease, or complications that caused and death. Do not enter a shock, or heart failure. List only one cause on each live. such as cardiac frespiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the bunal-trans Due to (or as a consequence of) Physician/Medical as the attending p IF FEMALE: asn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? ontributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes been (24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page this certificate 2 T No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 3 No 10 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: completely filled in by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

certificate be executed P.O. Box 68760, The law requires that the Division or Vital Records, or Attending Physician: To the Hospital

Baltimore, Maryland 21215-0036

Registrar

31. Date filed (Month, Day,

29b. Signature and title of

838 Green Tree

29d. Date signed (Month, Day, Year)

1116107

30. Name an acc use of death (Item 23a) (Type, Print) don who completed

ertifier

7 2007

320Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar 1. Decedent's Name (First, Middle, Last)			tificate of			3. No.2 () () 7	35702
26 166	Physicia /Medic		EVELYN			BROWN		NOVEMBER	Day 2007	4:30 P M
	Examin	-	4a. Facility Name (If not institution, give street			* .	r Location of Death		4c. County of Death	
	Funeral		105 RUTH EAGER COUP 5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)		If Under 24 Hrs.	8. Date of Birth	BALTIMO	nplace (State or Foreign
Ε	Director		215-03-4936	² X ^F 89	Yrs.	Months Days	Hours Min.	(Month, Day, Y	918	VA
	ryland how at		10a. State 10b. County		Town or Loc		-			10d. Inside City Limits
	he Ma 28a-f s otified	Director	MD BALTIMORE	BA	LTIMOF			100	g. Citizen of What Co	1 □ Yes 2 No
	3a or 3	I Dir	10e. Street and Number 105 RUTH EAGER COUR	·T		10f. Zip Code 2120	18	109	U.S.A.	*
	r death	Funeral	11. Marital Status	as Decedent Ever in U.S	i. 13. V		lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the Merical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 3 ☐ Widowed 4 ☐ Divorced Y	☐Yes 2X No Yes, Give ear or Dates:		l □ Yes 217 No	Specify:		Specify:	WHITE
215-0036	72 hou natura ical E	eted	15. Decedent's Education (Specify only highest grade con	n npleted)	(Give	lent's Usual Occup	during most of work	ding 1	6b. Kind of Business/l	industry
121	within ene. than "	Completed	Elementary/Secondary (0-12) C	college (1-4or 5+)		OO NOT use retired PRIETOR	d) -		MAR-LEE SA	ALES
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Maryland		안	ISADORE		ENSTE I		MARY		City or Town, State, 2	GANN
	s 1 and 2 should f Health and Mei item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. F			-			RE, MD 212	•
Baltimore,	0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remo	20b. Pl.	ace of Dispo	sition (Name of natory or other pla	ce)	Date 20	0c. Location - City or	Town, State
<u>E</u>	F 42 ->		4 Donation 5 ☐ Other (Specify) 21. Signature pf Funeral Service Licensee	HAR	SINAI		, ,	•	WINGS MILI ON & BROS.	
g	permit. Departi Imports any Inj		I an Man I e	<i>_</i> .					IKESVILLE	
	<i>'</i>		23a. Party. Enter the disease, or complication shock, or heart failure. List only one ca			1		or respiratory arres	st,	Approximate Interval Between Onset and Death
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	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):					
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09/89	tificate be executed ig physician and as the burial-transit	edical	d							
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1	w requires that the de been signed by the s should be detached	y Phy	Part II. Other significant conditions contribu	iting to death but not resu	Iting in the ur	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records ,	equires en sign ould be							1 ☐ Yes	s 2 No 3 Pr	robably 4 Unknown
ě	e law r has be je 2 sh	Completed						24a. Was an autopsy perform	prior to	topsy findings available completion of cause of
Vital			25. Was case referred to medical				26 Place of Dea		☑No 1□Yes	2 No
	Physicia this cer al direct	To Be	examiner? 1 Yes 2 No Hospi	tal: 1	ER/Outpatier		ner: 4 Nursing H	ome 5 Residen	nce 6 □Other (Spe	cify)
ouo	ding Ph h. : After th funeral		Natural 5 ☐ Pending	Ba. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ryat rk? ∣Yes 2∐No	28d. Describe hov	w injury occurred	
Division or	Atten er deatl rector: by the	Certification:	a Could not be	Be. Place of injury - At hor building, etc. (Specify				28f. Location (Stre City or Town,	eet and Number or Ri	ural Route Number,
5	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physicia	n: To the best of my know		h occurred at the ti	me date and place			n stated
	Hos 124 ho Fe Fun	Medical	(Check only 2 Medical Examiner:	On the basis of examinat and manner stated.	ion and/or in	vestigation, in my	opinion, death occu	rred at the time, da	ite and place, and due	e to the cause(s)
	Vithir Comp	Me	29b. Signature and title of certifier			29c. Licens	se number		d. Date signed (Mont	
	10		30. Name and address of person who complete	ated cause of death (Item	23a) (Tyne	Print)	5/70	1 1/1	luvember =	mD 21215
	Y		Ruser 1 K. Roby	m.0 2433	Wez	1 . 1	are ave 3	vix 22 1	30) Timore	mD 21215
	Sta Registi		31. Date filed (Month; Day, Year)	32. Registrar's Signat	ure	9-0-				
DH	MH 17 Rev 1/2	_	NOV 0 7 2007	A A A	4	acade s				
					ORI	GINAL				

Physician /Medical Examiner

Funeral Director

Director

Be Completed by Funeral

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Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

29a. Certifier

30. Name and

29b. Signature and title of certifier

21. Date filed (Menty) Day, Year)

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	Please		Print in Black					-	-	e.
For State Registrar		State of	f Maryland / D		rtment of I <i>tificate of</i>		Menta	al Hygien Reg. No	000	7 35703
I. Decedent's Name	e (First, Middle, L	.ast)						te of Death		3. Time of Death
Helen	Calho	-eath					-	onth Da tober a	- No. of the con-	67 5:50 PM
la. Facility Name (/			nber)		4b. City, Town, o	or Location of Death		-	c. County of D	
Worth	Jest 1	tospital	Center		Rand	10/157000)		Kaltin	nove
. Social Security N		Sex 1 □ M 2 ▼ F	7. Age (In yrs. last bir	Months Days Hours Min. (Month, Day, Year)					9.	Birthplace (State or Foreign Country)
219-28-4 Jsual Residence of			73	115.			JA	N. 9, 1	934	MD
Ioa. State	10b. County		10c. City, Towr	n or Loca	ation					10d. Inside City Limits
MD			BALTI	MORI	Ε					1 X Yes 2 □ No
I0e. Street and Nu	mber				10f. Zip Code			10g. C	itizen of What	t Country?
1040 E.	33RD ST.				21218			U	SA	
11. Marital Status		12. Was Dece Armed For		13. W	as Decedent of I Yes, specify Cub	Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yoto Rican,	es or No- etc.)		American Indian, Vhite, etc.
	ried 2 Married	If Yes, Giv	re		□Yes 2⊠No				Specify:	BLACK
3 Widowed		Year or Da		Decede	ent's Usual Occu	nation		16h	Kind of Busine	
	15. Decedent's cify only highest g	rade completed)		(Give k		during most of work	rking	100.1	and or Dualife	ooo maaany
Elementary/Second 12TH	, , ,	College (1	-4or 5+)		LTH AIDE				HOSPIT	AL
17. Father's Name		st)				18. Mother's Nam	ne (First	, Middle, Maide	n Surname)	
ROBERT S	TOKES					MYRTLE	WIN	KLER		
19a. Informant's N		(Type. Print)	19b	. Mailing	Address (Stree	t and Number or Ru	ural Rout	te Number, City	or Town, Sta	te, Zip Code)
CHARLENE	STREET/	DAUGHTER			IBERTY I	PL., WINDS	SOR I	MILL, M		
20a. Method of Disp	•	☐Removal from \$	cemete	Dispos ry, crem	ition (Name of atory or other pla	ace)	Date	1115	ocation - City OT GAR	RISON FOREST
	5 Other (Spec				ON FORES					LLS, MD 21117
21. Signature of Fu	uneral Service Lic	ensee	f.			ess of Facility WES EASTERN A				
23a. Part 1. Enter t	the disease, or co	mplications that c	used the death. Do rach line.	not ente	r the mode of dy	ing, such as cardiac	c or resp	iratory arrest,		Approximate Interval Between
Immediate Cause	(Final	1	2 ASIS							Onset and Death
resulting in death)		Due to (or as a consequence	of):						
Sequentially list co	anditions	b								
if any, leading to in cause. Enter Unde Cause (Disease or	mmediate erlying	Due to (or as a consequence	of):						
Cause (Disease or that initiated events resulting in death)	S	c		of):						
.country in doubly		Due to (or as a consequence	or):						
		d								
IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknowr	2 months?	1 ☐ Live b	come pf pregnancy irth 2 Fetal death ant at time of death own		Ectopic pregnand Other <i>(specify)</i>	су			23d. Date o Month	
Part II. Other signi	ificant conditions	s contributing to de	eath but not resulting in	n the un	derlying cause gi	iven in Part I.	2	3e. Did tobacco	use contribu	ite to the cause of death?
Cox	00							1 ☐ Yes	2□ No 3[Probably 4 Denknown
AK	F-acu	the renal	failne				2	4a. Was an autopsy	prio	re autopsy findings available r to completion of cause of
Ca	ardiom	yorthy					1	performed? ☐ Yes 2☐√		Yes 2 No
examiner?	med to medical	Henrital N				26. Place of Dea				
1 Yes 2		1 1	·	.	3 DOA	4 LI Nursing H	_	Residence		(Specify)
27. Manner of Dea	tn 5						28d. Describe how injury occurred			
2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not									

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

State Registrar

7

erson who completed cause of death (Item 23a) (Type, Print)

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DU056632

MD 5401 Old Cowt Rd Randallstown, MD 2133

29d. Date signed (Month, Day, Year)

			State of Maryland / Department of He		-	e o o ~	05701
			1 - For State Registrar Certificate of De		Reg. N	7	35/04
	Physici		Decedent's Name (First, Middle, Last)		Date of Death Month Da	ay Year	3. Time of Death
	/Medic		ROMELIA JOHNSON CARTER	7	Vovember		420 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo		44	c. County of Death	
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year	Ore If Under 24 Hrs. 8. I	Date of Birth (Month, Dey, Year	9. Birth:	place (State or Foreign
7	Director		219-52-8351 DM 2011 58 Yrs.	Hours Min.	Ay 27,1	949 M2	FRYLAND
7	land w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	10d. Inside City Limits
11:25	Mary a-f sh	tor	MARWAIN NIA	TIMORE	= CITI	/	1∕XYes 2 No
Com	or 288	Director	10e. Street and Number 10f. Zip Code	10	109/0	Citizen of What Coul	ntry?
. 20°	s 23a	ral	1904 N. MILASKI STREET	21211		451	7
eli	ter de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	Mexican, Puerto Rica	an, etc.)	14. Race - Americ Black, White,	
Ronelid 5-0036	ral', o	þ	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates:	Specify:		Specify: BL	ACK
c: (Rone 21215-0036	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during the DO NOT use retired)	on ring most of working	16b. I	Kind of Business/In	dustry
, (within ene. than	dmc	Elementary/Secondary (0-12) 3 College (1-4or 5+) 5 TUDEN		C	PANSTA	TE COLLEGE
		Be C		8. Mother's Name (Fi	irst, Middle, Maide	on Sumame)	il dilica
Vlar V	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Man	ToB	JOSEPH BROWN.	HATTIE	· B.	JOH	NSON
$\widehat{\mathcal{D}}_{\mathcal{C}}$ Maryland	s 1 and 2 should f Health and Mer item 27 is marke othar traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	d Number or Rural Ro	oute Number, City	or Town, State, Zip	Code)
_	1 an Hea tem 2		RAYMOND CARTER (SON) 7 20a. Method of Disposition (Name of	Date	20c. 1	Location - City or To	own, State
Baltimore	90 = 5		1 ØBurial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) **Commetery, crematory or other place) **KING MEM, PARK	1 11 200	-07 111	1001411	W. M.D
alti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of		N. Fulto	n Avenue	140. 21217
<u> </u>	30E # 8		Latuch N. Williams Joseph H.	Brown Jr.	. Funera	1 Home	Baltimore
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.	such as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	Chriel			
	Examiner		Due to (or as a consequence of):				
/	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
V	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
760,	ate be executed hysician and he burial-transit	calE	Due to (of as a consequence of).				
	ifficate g phys as the		0.				
XOX	th cert tendin r use	an/M	IF FEMALE: 23b. Was decedent pregnant 1			23d. Date of deliv	rery Day Year
O. E	ne dea the at hed fo	Physician/Med	in the past 12 months? 1			Wioriai	Day 1 ear
9.	that the ed by detac	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I.	23e. Did tobacco	o use contribute to t	the cause of death?
rds	quires in sign	ed by			1 🗆 Yes	2 □ 1 10 3 □ Pro	bably 4 □Unknown
900	law re as bee 2 sho	Completed			24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
- A	The ate ha	Com			performed? 1 Yes 2 N	death?	
Vita	ician: certific	Be	examiner?	26. Place of Death (C			
of	Phys er this eral di	1; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	at 28d.	I. Describe how inj	6 ☐Other (Special jury occurred	(y)
ion	inding ath. ir: Afte	atio	2 Accident investigation M 1 ☐ Yes	as 2□No			
Division of Vital Records, P.O. Box 68	r Atte ter de irecto irecto	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Street a City or Town, Sta	and Number or Run ite)	al Route Number,
۵	pital c	i Cel	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time,	data and place and	I due to the sever	(-)	etated
	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.				
	To th within To th	Me	29b. Signature and title of certifier 29c. License n		29d. D	Date signed (Month,	Day, Year)
	1		D.	40854		11/2/2	207
	P		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Ral	tenor	21200	
	Sta	te	31. Date filed (Month, Day, Year) 32. Figistrar's Signature	1,0011		21002	
	Registr		NOV 0 7 2007				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician C\oss Varione 2007 3705 Normpo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore County Baltimore Augsburg Lutheran Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) March 12 1918 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Days Hours Min. 1 □ M 2 □ F Brooklyn, New York 212 07 0484 89 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 USA 6811 Campfield Unit 30 within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status I □ Yes 2 📉 No f Yes, Give 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 □ Yes 2 □ No þ Specify: 3 Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Housekeeping Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be finance of the second se Agnes Schlecht Richard Lance ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) es 1 and 2 sh of Health and item 27 is m 6811 Campfield Road Unit 30 Baltimore, Maryland 21207 Clarence M Class (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State 70 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Metro Crematory Inc. November 6 2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify 21. ig atu/e of Funeral Service Lic ins/ e 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ischemic leaves /Medical Due to (or as a consequence of): Examiner COrena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dies to for as a consequence of Examiner as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical aftending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 → No 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ م 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed neec 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1□ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. s after death. investigation 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D filled 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37573 November 5, 2007 30. Name and address of person who complete of death (Item 23a) (Type, Print) 13 Zibell Main MO MD reisterstaur 당. 32 Signature 31. Date filed (Month, Day, Year) State Registrar NOV 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 10:20 PM EON) CALLOWA 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Ctr INDALE ORG If Under 24 Hrs. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1/2M 2□ F Months Days 236-30-7095 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other traumatic event, the Madical Exercit er must be notified at 1 Pres 2 No Director Altimore 10e. Street and Number Citizen of What Country? 212 "natural", or Itams 23a by Funerai 12. Was Decedent Ever in U.S. Armey Forces? 1 Le Yes 2 Le No If Yes, Give Year or Dates: Www. 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or Ita 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No JACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AlloWAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Paral Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau nallE 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemptery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 Removal from State * 4 Dogation 5 Other (Specify) Enterprise 200 TIMORE 21. Sign oure of Funeral Service Licensee ZUNERAL BROADWAY 23a Part1. Enter the disease, or complications that canded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA Proysician EMIN 172 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PSCHOO-OBSTRUCTION CHRONIC 1 Yes 2 No 3 Probably 4 Doknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☑ No Other: Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred 5 Pending investigation Natural Injury after death. 1 Tyes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dirac 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-1-2007 PHYSICIAN DO064533 30. Name an intress of person who completed cause of death (Item 23a) (Type, Print) LEVIND TILE - HEBROW MCRIATIVIC 5

DHMH 17 Rev 1/2001

Registrar

BABATUNDE

31. Date filed (Month, Day, Year)

NOV 0 7 2007

My)

32 Registrar's Signature

AJANI

2434 W-BELVEDERE AVE.

BATTIMORE MJ21215

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Nov. 3 2007 Physician 1:30a^M Marjorie ٧. Creamer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Middle River 3520 Wheelhouse Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Min.

8. Date of Birth
(Month, Day, Year)
July 9, 1916 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Maryland 1 □ M 2 🔀 F 91 217-24-9893 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Middle River Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 USA 3520 Wheelhouse Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) own home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amos C. Dawson Daisy Watts ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5731 Butterfly Lane Frederick MD 21703 Louisa Tyeryar / niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 11/5/07 Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lea **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed and burial-trar Due to (or as a consequence of): ng physician a as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical The law requires that the death certificate ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tor: After this certificate has been signed the funeral director, page 2 should be det 3 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com 046 ₩egistrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 2007 Registrar

DHMH 17 Rev 1/2001

Amend 4a, per MD, 10e, perFD, 98/3, 11///0/TI State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER 3 2007 7:00 A ROBERT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 8412 DORIAN ROAD BALTIMORE 8. Date of Birth (Month, Day, Yea) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days 1 X M 2□ F Hours 91 Director 218-01-8598 Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8421 21208 U.S.A. 8412 DORIAN ROAD Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status WHITE 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LAW ATTORNEY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be APT COHEN FANNIE LOUIS ဥ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3742 CUMBERLAND STREET NW - WASHINGTON, DC 20016 MARILYN BONO / DAUGHTER Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition BETH EL MEMORIAL permit. Pages 'Department of HIMportant: If ite any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RANDALLSTOWN, MD 11/05/2007 PĀRK SOL LEVINSON & BROS.. INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROSTATE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit the Hospital or Attending Physiclan: The law requires that the death certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ate has been signed by the page 2 should be detached 9 HInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 W No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform yes death? 1 ☐ Yes 2 No 1□ Yes 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Yes Certification: To this 27. Manner of Feath 28c. Injury at Work? 28d. Describe how injury occurred funeral 28b. Time of 28a. Date of Injury After 1 (Month, Day Year) Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No r death. 24 hours after death e Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0050414 10 aucat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Luthenville MD 32. Redistrar's Signature State Registrar

07-08525 David J Claar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 35709 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 2, 2007 1342 hrs **Medical Examiner** Claar David J. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Allegany **Cumberland Memorial Hospital** Cumberland 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY **Funeral** oreign Director Months Days Hours 05/29/1951 188-38-3746 Country) 56 1 XM 2 Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No 23a or 28a-f show notified at once, PA Bedford Claysburg hours after death with the Maryland rector 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 334 Beaver Dam Road 16625 United States 百 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 XMarried Yes 2 X No White If Yes, Give Year Yes 2 X No specify: Specify: Widowed 4 Divorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. the Medical Construction Construction Worker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) event, Mayberry Claar Shirley Smith is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 334 Beaver Dam Road, Claysburg, PA 16625 Debra K. Claar, Wife If item 27 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X Cremation 3 X Removal from State 11/07/2007 Altoona, PA Forsht Crematory tant Other Specify Donation 5 or 22. Name and Address of Facility 21. Signature of Fuj eral Service Licensee M01113 Sorge Funeral Home 422 N. Juniata Street, Hollidaysburg, PA 16648 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or you cause on each line. Approximate Interval Physician etween Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical attending physician or use as the burial -X UNPENDED AMENDED, 27, perME, g874, 12/11/07 TT Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 2 σ. Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed? ✔ Yes 2 2 Nο No 1 V Yes this certificate or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) director, of Vital Be examiner? Other₄ Hospital: 2 V ER/Outpatient DOA Nursing Home 5 Residence 6 Other Inpatient 1 ✓ Yes After (28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: X Natural Division Yes 2 Pending death. the Director: 2 Investigation Accident within 24 hours after d To the Funeral Direct completely filled in by in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 3, 2007 O.C.M.E. Mirrie 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 200

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Certif	ficate of L	Death		Reg. No.		
¥.	Physici	an.	1. Decedent's Name (First, Middle, Last)					2. Date of D	eath Day	Year	3. Time of Death
(i)	/Medic			Ping-Jen Ch				No.	vember		12:43 p. M
	Examir	er	4a. Facility Name (If not institution, give s	treet and number) win Rivers Rd. Apt C-2	41	b. City, Town, or		_{eath} Columbia	4c. County of Death Howard		
			5. Social Security Number 6. Sex	7. Age (In yrs. last bir	thday) I	f Under 1 Year	If Under 24		irth		
e-	Funeral Director					Months Days		Ain. (Month, E	st 13, 192	20 Silitip	lace (State or Foreign try) China
	yland		10a. State 10b. County	10c. City, Town	n or Locati	ion				1	0d. Inside City Limits
	e Mar 8a-f sl	ctor		oward		C	Columbia				1 □Yes 2 No
	th with th 23a or 24 ust be no	Funeral Director	10e. Street and Number 10551 Twin Rivers Rd.	Apt C-2		10f. Zip Code	2104	4	10g. Citize	n of What Coun U.S	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		s Decedent of Hi es, specify Cuba Yes 2 XNo	spanic Origin' n, Mexican, P Specify:	? (Specify Yes or N uerto Rican, etc.)		. Race - Americ Black, White, pecify:	
2-0	72 hc 'natul dical	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a.	(Give kine	t's Usual Occupa d of work done d	luring most of	working	16b. Kind	of Business/Ind	dustry
121	within ene. than '	ldm	Elementary/Secondary (0·12)	College (1-4or 5+)	`life. DO	NOT use retired,	rofessor	J		Educ	ation
q 5	filed v Hygie ther i	ပိ	17. Father's Name (First, Middle, Last)					Name (First, Middi	e. Maiden Su	urname)	
an	ild be lental ked o ic eve	То Ве	, , , , , , , , , , , , , , , , , , , ,	an Chi				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Ku C		
Mary	is 1 and 2 shou of Health and M Item 27 is mai other traumal		19a. Informant's Name/Relationship (<i>Typ</i> Mrs. Karen Green					r Rural Route Num vay Ellicott C			
altimore, Maryland 21215-0036	Pages 1 ar ment of Hea ant: If Item 3 ury or other		20a. Method of Disposition 1 ☐ Burial 2 DC remation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State 20b. Place of cemeter	ry, cremate	on (Name of fory or other place view Crema		Date - 0 - 0 - 7	20c. Loca	ttion - City or To Baltimo	
Balt	permit. Departimport any Inj	Į Jį	21. Signature of Funeral Service License	ott City, I	ity, MD 21043						
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compile shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	pations that caused the death. Do not be cause on each line. Due to (or as a consequence	5717	he mode of dying	g, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
7		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	bf):						
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rds, P.	w requires that been signed by should be deta	ed by Ph	Part II. Other significant conditions conf	tributing to death but not resulting ir	n the unde	rlying cause give	en in Part I.		tobacco use		ne cause of death?
Vital Records, P.O	sician: The law re certificate has bee irector, page 2 sho	Completed						24a. Wa aut per 1∐ Yes	opsy formed?	24b. Were auto prior to cor death?	psy findings available inpletion of cause of
Zii	ician certifii ector,	Be	25. Was case referred to medical examiner?	ospital:		Otho		Death (Check only	one)		
o	Phys this ral dir	2	1 Yes No	1 Inpatient 2 EH/Ou	tpatient Time of	3 DOA Othe	4 LI Nursir	ng Home 5 Re		Other (Specify	y)
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Division or	I or Atten after deat Director: I in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, fa building, etc. (Specify)			20.10		(Street and I own, State)	Number or Rura	l Route Number,
	To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) (Check only one)	ician: To the best of my knowledge er: On the basis of examination an and manner stated.	e, death oc id/or inves	ccurred at the tim	ne, date and p pinion, death o	lace, and due to the	e cause(s) ar e, date and p	nd manner as s lace, and due to	tated. the cause(s)
	To th withir To th	Me	29b. Signature and title of Gertifier	redman Do		29c. License	number	11	29d. Date :	signed (Month,	Day, Year)
	5		30. Name and address of person who sor	npleted cause of death (Item 23a)	(Type, Prin	nt)	(OL)	MARIA	MO.	21021	
	Sta Registr		31. Date filed (Month, Day, Year)	32 Segistrar's Signature	Som	the state of the s	C - L	10000	11.7	VIO E	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar		State	of Maryla	and / Dep	partment of F ertificate of a	Death	Mental Hygi	ene ₂	007	35711	
Physic /Med			Decedent's Name (First,		Rol		Carlisl				Day ember 4		3. Time of Death 2:00 a. M	
Exam			a. Facility Name (If not inst		e street and no urel Regio	onal Hosp							e George's	
Funera Directo			5. Social Security Number 214-30-281		ex io M 2□ F	7. Age (In)	yrs. last birthda 79 Yrs.	Months Days	If Under 1 Year If Under 24 Hrs. 8. Date (Mo. Fe			Birth 9. Birthplace (State or Country) ary 26, 1928 Maryland		
/aryland f show ed at			Usual Residence of Deceder 10a. State 10b. C Maryland		Howard	10c.	. City, Town or		Columbia				10d. Inside City Limits 1 ☐ Yes 2 No	
with the 3a or 28a-		a Dilec	10e. Street and Number 5364 Red La	ke Cou	rt		_	10f. Zip Code	21045	1	0g. Citizen	of What Cou	intry? S.A.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at			11. Marital Status 1 Never Married 2 3 Widowed 4 Div		12. Was De Armed I 1 Yes If Yes, O Year or	cedent Ever i Forces? 2 10 No sive Dates:	in U.S. 1	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		Race - Amer Black, White ecify:		
ithin 72 hourne.	Total a	Completed by	15. De	edent's E highest gr	ducation ade completed		I (G.	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Janitor			16b. Kind o	of Business/I Jai	nitorial	
d be filed wental Hygier ked other the cevent, the	8	17. Father's Name (First, Middle, Last) Henry E. Carlisle					18. Mother's Name (First, Middle, Maiden Surname) Gertrude M. Arthur							
and 2 shou ealth and M m 27 Is mar			19a. Informant's Name/Rei Ms. Deboi			Careg		ailing Address (Street 11735 Home					ip Code)	
Pages 1 and 2 nent of Health nut: If Item 27 I			20a. Method of Disposition 1 Burial 2 DCrem 4 Donation 5 0	ation 3 [her (<i>Speci</i>	□Removal from	m State		sposition (Name of crematory or other pla Bayview Crem	istion (Name of natory or other place) syview Crematory 11/06/07			20c. Location - City or Town, State Baltimore, MD		
permit. Pages Department of Important: If It any Injury or o	ouce.		21. Signature of Funeral S	XM	uelts	ess of Facility Funeral Hon Old Columbi	a Pike Ellicott City, MD 21043							
Coate be executed Coate be executed Examine physician and sthe burial-transit	al er	Examiner	23a. Part1. Enter the disa shock, or neart failui immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to mine of a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(a. Due 1	to (or as a cor	nsequence of):	Lymph	DMA				Approximate Interval Between Onset and Death W.C. 3 Months	
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vical rsician: 7 s certifical lirector, p	- 1	o Be (25. Was case referred to rexaminer? 1 ☐ Yes 2 No	nedical	Hospital: 1)	Inpatient	2 ER/Outpa	atient 3 DOA Of	thor	ath <i>(Check only o</i> Home 5 ☐ Resid		Other (Spe	cify)	
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To the Hospital or Attending Physician: To the Hospital or Attending Physician: To the Funeral Director: After this certifical completely filled in by the funeral director.		Medical C	29a. Certifier (Check only one)	ertifying F edical Ex	aminer: On th	the best of m e basis of exa anner stated.	amination and/	death occurred at the or investigation, in my	opinion, death occ	curred at the time,	date and p	lace, and du	e to the cause(s)	
To th Within To th		ž	29b. Signature and title of	certifier	1	A H	Δ,	29c. Licer	NIT I		29d. Date :	signed (Mon	th, Day, Year)	
2			30. Name and address of	person wh	o completed c	ause of death	(Item 23a) (T)	/pe, Print)	RONT	2491-21	1 WV	Air or	MUJUN	
Regi	Stat istra		31. Date filed (Month, Day	Year)	2007	2 Hegistrar's	Signature	Coarte		u Je ou			, 1- 30 00 10	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 6:15 AM 4,2007 J. November Douglas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Belair 8. Date of Birth (Month, Day, Year) April 4,1924 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🕱 F Kentucky 212-56-7575 83 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Middle River Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 21220 USA 1 Silver Maple Court 23a Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. or items 11. Marital Status should be filed within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Housewife 8 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Lucy Jane McCulley Harry Hamil 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Health a 1 Silver Maple Court, Middle River, MD. 21220 Husband Arthur Douglas Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 9, 20a. Method of Disposition Department of h Important: If ite any Injury or of 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sacred Heart Of Jesus Dundalk, MD. 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 21. Signature of Funeral Service Licensee Ball 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) econdary to intracranial bleeling **Physician** tail hours Due t (or as a conse unice of): /Medical with midline Shi Examiner intracranial hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the buriaf-transit el rtension o (or as a consequence of) stage demention Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 XNo 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at id be detached fo 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2**23** No 1 TYes 2 No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: within 24 hours after death. To the Funeral Director: After (Month, Day Year) Injury 1 Natural 5 □ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide the Hospital or A 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bangaria, $\mathcal{M}\cdot\mathcal{D}$. 1006564 ia 500 upper Chesapoake Dr. Bel Air, Maryland 21014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Bangoria 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

NOV 0

2007

Donglas, Laura M80048222

ORIGINAL

			_ FOF	State of Marylan				viental Hy	giene				
			State Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate of D	Death	2. Date of De	Reg. No. 2	007	35713		
	Physicia	an		RATINE DA	ARDE.	\sim		Month	Day	Year 200	3.4 Ime of Death		
	/Medic Examin		4a. Facility Name (If not institution, give st		110pc	4b. City, Town, or	Location of Death		4c. Cou	inty of Deat	CEA		
		•	MD. GENERAL	HOSPITAL			MERE,	MD	3	4150.	CITY		
j.	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. M 2XF	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ay, Year)	9. Birth	place (State or Foreign intry)		
ŀ	Director	ŀ	216-50-0174 Usual Residence of Decedent	60	113.			FEB. 8	3, 1947		MD		
	nyland how Lat		10a. State 10b. County	10c. Cit	y, Town or La	cation					10d. Inside City Limits		
	Ba-f s	Director	MD	BAI	LTIMORE						1 X Yes 2 No		
	with the		10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	intry?		
	ns 23	Funeral	1510 PENNSYLVANIA A	2. Was Decedent Ever in U	.S. 13. ¹	21217 Was Decedent of His If Yes, specify Cubar	spanic Origin? (S	pecify Yes or No	USA 0- 14.1	Race - Amer	ican Indian,		
0000	be filed within 72 hours after death with the Maryland ntal Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔁 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cubar 1 □ Yes 2🏿 No	n, Mexican, Puerti Specify:	o Rican, etc.)		Black, White ecity: BL			
0	72 ho 'natur dical	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa kind of work done di	uring most of wor	king	16b. Kind o	f Business/I	ndustry		
7	within sne. than '	du	Elementary/Secondary (0-12) 1 2TH	College (1-4or 5+)		DO NOT use retired) ES ASSOCI			ਸ਼ਾਰ	'AIL S'	MAE		
7 0	Hygint, ther		17. Father's Name (First, Middle, Last)		SAL		18. Mother's Nan	ne (First, Middle	1		ЮШ		
<u> </u>	Mental Mental arked or	To Be	EARL T. HAYES				DORIS I	ORSEY					
Mary	2 should and Mer is marke aumatic		19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (Street a	nd Number or Ru	ıral Route Numt	ber, City or To	wn, State, Z	ip Code)		
e,	l and lealth im 27		SABRINA DARDEN-HIL			28 CANBERR		ESSEX, N			Ch-h-		
_	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any Injury or other traumatic. once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State		osition (Name of matory or other place			8710 L				
allillo	permit. P Departme Importan any injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	e		IEMORIAL 2. Name and Address		1/2007 SLEY CHA			L, MD 21244		
Ď	Depar Impor any ir		Danell L.	Hunter		2007-09 E					21231		
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
,	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consect ATRIM	ive 1.	HEARY F	41LURE				Onset and Death 2 DAYS		
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Ì.	F #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):						Jimor 1 11.3		
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to for see a series									
8/00,	icate be executed physician and s the burial-transit			Due to (or as a consec	quence or).								
200	ificate g phys	edical	d.										
O. 00X	The law requires that the death certificate ate has been signed by the attending physipage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	3c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3	□Ectopic pregnancy □ Other <i>(specify)</i>			23d.	Date of deli Month	very Day Year		
Ţ.	that the pool of t		Part II. Other significant conditions conf	tributing to death but not res	ulting in the u	nderlying cause give	n in Part I.	23e. Did	tobacco use	contribute to	the cause of death?		
	equires en sign ould be	ed by	DIABETES ME	LLINS, POT	orly !	CONTROLL	ED	1 🗆	Yes 2 N	lo 3 Pr	obably 4 □Unknown		
Hecords,	law re as ben 2 sho	Completed	HYPERTENSION	√	ĺ			24a. Was	s an 2	4b. Were au	topsy findings available ompletion of cause of		
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Vital	slcian certifi rector	o Be	25. Was case referred to medical examiner?	ospital:	ED/Outration	othe Othe	26. Place of Dea						
0	g Phy er this eral di	-	27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o	IL 3 DOX	4 LI Nursing F	lome 5 ☐ Res 28d. Describe			ify)		
io I	ath. or: Aft	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		r? fes 2 □ No						
Division of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	fy)		28f. Location (Street and Number or Rural Rou City or Town, State)						
	the Hospi in 24 hou the Funer	Medical	29a. Certifier 1	ician: To the best of my knower: On the basis of examination and manner stated.	owledge, deat ation and/or in	ivestigation, in my of	oinion, death occu	e, and due to the urred at the time	e cause(s) and e, date and pla	d manner as ace, and due	stated. to the cause(s)		
•	To Toor	2	29b. Signature and title of certifier Non-Care	mozacy		29c. License	225		29d. Date si	igned (Monti	n, Day, Year) C, 2007 1244		
F)		30. Name and address of person who con	mpleted cause of death (Itel	m 23a) (Type,	Print)	ITU RIL	10 1	Z m M	10 7	12 411		
	Sta Registr		31. Date filed (Month, Day, Year), NOV 0 7 200	32. Registrar's Sign	ature	sale)	17 174	10, 0	ry o	10 0	1274		
					3								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #21, perFH, g873, 11/7/07 TT Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** OCT. 31, 2007 08.2514 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner FAYETTE HEALTH & REHAB BALTIMORE 8. Date of Birth (Month, Day, Year) NOV. 20, 1955 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□ F Months Days Hours Yrs. 161-01-302 51 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits rai', or items 23a or 28a-f ehow Examinar must be notified at 1 XYes 2 No MD BALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 630 WILDWOOD PKWY 21229 USA death Funerai . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 NDivorced "natural" Completed is marked other than "naturalization" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Efementary/Secondary (0-12) College (1-4or 5+) 10TH TRUCK DRIVER TRUCKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental 2 EDWARD FRANCIS ALMA DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 630 WILDWOOD PKWY., BALTIMORE, MD 21229 EDWINA DORSEY/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 5500 O DONNELL ST. permit. Pages
Department of It
Important: If ite
any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW 11/6/2007 BALTIMORE, MD 21224 21. Signature of Fine all Service Licensee Wasley Chavis, 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. Jr. 2007-09 EASTERN AVE., BALTI
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2007-09 EASTERN AVE., BALTIMORE, MD Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINOMA Physician 20UKMUUZ /Medical Examiner rep Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ysiclen and e burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical the th IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) the Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform certificate 2/ No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Beath (Check only one) Hospital: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 27. Mann Death 1 atural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signatu and title of 29d. Date signed Month, Day Year)

State Registrar

31. Date filed (Month, Day, Year) 2007 MON 0

30. Namela

32. Registrar's Signature 1931 Pans

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Stat	te of	Mar	vland /	Depar	tment o	f Health	and M	ental Hv	/aiene	

		•	For State Of Maryland State Registrar		tificate of L			g. Noa a a a	OFTIE		
I			1. Decedent's Name (First, Middle, Last)				Date of Death Month		3. Time of Death		
	Physicia /Medic	_	Exequiel L. David				11	5 200	7		
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Dea			
	Funeral		Prince George's Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	Cheverly If Under 1 Year	If Under 24 Hrs. 8.	Date of Birth	Prince Ge	thplace (State or Foreign ountry)		
	Director		463-67-8450 ¹ X ^{M 2□ F} 48	Yrs.	Months Days		(Month, Day, 4/10/19		ippines		
	land ow t	-	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	cation		-		10d. inside City Limits		
	Mary a-f sho Ified a	itor	Maryland Prince George's Bow	ie					1 ☐Yes 2 ☐ No		
	ith the	Director	10e. Street and Number	-	10f. Zip Code		10	g. Citizen of What C	ountry?		
	ath w	lal	2915 Tarragon Lane	140.1	20715			Philipp 14. Race - Am			
	ter de Item: Iner n	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Xeys 2 □ No	-		ispanic Origin? (Specify n, Mexican, Puerto Ric	an, etc.)	Black, Whi			
920	urs af al", or Exam	by	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 1 □ Never Married 2 □ No If Yes, Give Year or Dates: 84-88	1	□Yes 2X No	Specify:		Specify: As	ian		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup kind of work done	ation during most of working l)	1	6b. Kind of Business	s/Industry		
121	within ene. than '	dmo	Elementary/Secondary (0-12) College (1-4or 5+)		nspector	"	l F	Boeing Air	lines		
d 2	filed Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name (F					
lan	Jental Jental rked tic ev	To B	David M. David			Maria Lope	ez				
Maryland	2 should be f n and Mental I is marked of raumatic eve		19a. Informant's Name/Relationship (Type. Print)			and Number or Rural R					
	ss 1 and 2 of Health item 27 i		Maria Lopez David/Mother 20a. Method of Disposition 20b. Plan	2915	Tarragon	Lane, Bow	ie, Mar	cyland 20	715 r Town. State		
nor	0 0 		1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Me	tropo.	Litan	(8)					
Baltimore,	4. もだる。		4 □ Donation 5 □ Other (Specify) Cr. 21. Signature of Funeral Service Licesse?	emato 22		11/9/20	JO/ Al ert E.	lexand <u>ria,</u> Evans Fun	Virginia eral Home		
ä	permi Depar Impor any Ir		· LAH			polis Road					
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CO	aw require s been siç 2 should b	Completed	U				24a. Was ar		autopsy findings available completion of cause of		
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Division	Attend er death rector: , by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office	28f	Location (Sti	reet and Number or . n, State)	Rural Route Number,		
	Hospital or Attending 44 hours after death. Funeral Director: After tely filled in by the funer										
	e Hospital or A 124 hours after of e Funeral Direct letely filled in by	Medical	29a. Certifier (Check only one) (Check one) (Check only o								
	To the Hosp within 24 hou To the Fune completely fi	Me	29b. Signature and title of certifier	 	29c, Licens	se number	25	9d. Date signed (Mo	nth, Day, Year)		
1	Y, D		MA HOD I'M		D55	220		1/5/2007	_		
9	17,		30. Name and address of person who completed cause of death (Item 2	23a) (Type,	Print)			40 2079	35		
	Sta	to	31. Date filed (Month, Day, Year) 32. Begistrar's Signatu	os p	prive	Chever	4 ~	40 00 TT	27		
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DHMH 17 Rev 1/2001

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			For State Registrar		State of M	aryıan		artment of t rtificate of		id ivientai F	Reg. No	71111/	35716
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	Examir		4a. Facility Name (Ohns H		tosp		4b. City, Town, or Baltin If Under 1 Year	nore c	Death	4c.	County of Dea	thplace (State or Foreign
aŭ.	Funeral Director		263-57-12 Usual Residence of	85 of Decedent	1 M 2 € F	44	Yrs.	Months Days		Min. (Month, 9-6-1	Day, Year)	C	ountry) 7 York
	death with the Maryland ms 23a or 28a-f show r must be notified at	ctor	10a. State Florida	Broward		Davi	y, Town or Lo						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with th	Dire	10e, Street and Nu					10f. Zip Code				izen of What Co	ountry?
	sath is 23	eral		Longbow 1	Bend 12. Was Decedent	Ever in H	e 13	33331		2 (Specify Ves or		SA 14. Race - Ame	erican Indian.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Directo	11. Marital Status1 ☐ Never Mar3 ☐ Widowed	ried 2 🔀 Married 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2X No		Puerto Rican, etc.)	140-	Black, Whi	te, etc.
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Maryland	be find half	Be		(First, Middle, Last	9					•		i Surname)	
3	ould J Mer narke natic	P_C	Angelo C		(Time Print)		10h Maili	ng Address (Stree		ia Tinda		as Town State	Zin Codo)
Ma	d2sh chan 7 is r traur			lame/Relationship			j	. N. Long					zip Code)
	1 an Heal em 2		20a. Method of Dis	DiComo (H	iusband)	20b. F	Place of Dispo	osition (Name of	- :	Date		ocation - City or	r Town, State
Baltimore,	it. Pages 1 rtment of H rtant: If Ite njury or ot		1 ☐ Burial 2 4 ☐ Donation	☐Cremation 3 ☐ 5 ☐ Other (Speci		Foi		matory or other pla awn South	11	-10-2007	1		ale, FL
Bal	permi Depa Impo any ii		Bei	uneral Service Lice	Villem		97	2. Name and Addr 205 Belai	r Rd Ba	altimore,	MD 2		ome, Inc.
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1	6		30. Name and add	iress of person who	completed cause of	death (Iten	n 23a) (Type,	Print)					
ىلى	Sta		31. Date filed (Mo.	nth, Day, Year)	32. Regist	rar's Signa	ature		OU UNIT	n voolte 24	WU100	ATTUNOYE,	Maryland 21287
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 12:30 P M Beulah Hanson Mitchell Dayhoof November 4, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bel Air Harford Upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🕅 F 89 Jan. 27, 1918 212-14-3930 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No Director Harford Maryland Churchville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or be 809 Calvary Rd. 21028 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify. δ 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home s 1 and 2 should be filed w f Health and Mental Hygier tem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Emory Mitchell Isabel Grace Hanson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any Injury or other tra. 2006 Churchville Rd., Bel Air, MD 21015
of Disposition (Name of Date 20c. Location - City or Town, State James Bernard Davhoof Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimoré, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Socyice Licensee Mt. Zion UMC Cemetery 11-8-07 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Onset and Death Immediate Cause (Final CARdibrascular years **Physician** Atherosclerotic disease or condition /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1☐ Yes 2☑ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☑ No 2 Ai No or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a
To the Funeral L 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 135522 Maly West November 5 2007 30. Name and address of person wire completed cause of death (Item 23a) (Type, Print) Bel AIR MARYLAND 2 NORTH MARK Avenue 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,7$ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 3, Month **Physician** 12:15am M Ruth Cassell Gault Eyler November 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Hospice Dove House Westmnster Carroll 8. Date of Birth (Month, Day, Year) Mar 30, 1914 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 👽 F 215-42-4147 93 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a, State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Carrol1 Westminster 1 ☐ Yes 2 → No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 51 Ridge Road 21157 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 14. Race - American Indian 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked other than "natural", or Itel 1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Horse Racing Horse Race Drver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Gault Betty Fritze P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is m any injury or other traum Mr. Joseph Eugene Eyler (Son) 51 Ridge Road Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place)
All County Cremation 11/6/2007 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) HAIGHT FUNERAL HOME & CHAPEL, P.A. (Bosykesville, MD 21784 (410)-795-1400 21. Signature Funeral Service Licenses 23a. Part1. Enter the disease, or complications that squeed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the as signed by the attending d be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 Tachy cardia icate has been sig r, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Reflex Direase certificate has autopsy performed? Yes 20 No 2 No Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 \(\tau\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Hospice 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

4

State Registrar

Imanoe) 31. Date filed (Month, Day, Year) NOV 0



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Heighte Med Ctr; Westminster, MD 21157

H53939

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

			For State Registrar	otato or mary	Ce	rtificate of l		Reg. No	2007	35/19
+	Dhysicia		1. Decedent's Name (First, Middle, Las					Date of Death Month Da	y Year	3. Time of Death
	Physicia /Medic	-		VANS			. L	NOV	2007 County of Death	9:04 M
7	Examin	er	4a. Facility Name (If not institution, give	MOCPITAL		4b. City, Town, or	Location of Death	TOWN	BATT	IMORE
*	Funeral Director		5. Social Security Number 6. S	ex 7. Age (/	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year MARCH ()	Count	ace (State or Foreign ry) SYLVANIA
	pu ,		Usual Residence of Decedent 10a, State 10b. County	11/	Oc. City, Town or Lo	ocation		1		od. Inside City Limits
	should be filed within 72 hours after death with the Maryland not Mental Hyglene. Ind Mental Hyglene. Inarked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than "hedical Examiner must be notified at	ro	10a. State 10b. County	/4	oc. Only, Town of E	B	ALTIM	ORF		1 X Yes 2□No
	or 28a-	Funeral Directo	10e. Street and Number		F	10f. Zip Code	1161111		itizen of What Count	ry?
	ath wi	ral	5008 LOR.	LEY RD. A	PT. 137		2120	/	14. Race - America	an Indian
	fter de r items Iner n	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12 Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give			ispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White,	
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ore,	jes 1 an of Heal of Item 2 or other		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐		20b. Place of Disponentery, cre	osition (Name of matory or other place		~ ~	ocation - City or To	(
altimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other	-	4 □ Donation 5 □ Other (Specif	y)		EM PAR 2. Name and Addre		1-01 W	SODIAWA	MARYLAND
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	5		30. Name and address of person who	completed cause of death MD / 32. Sistrar's	VDRTHV	VEST HO	SPITAL	RANDA	LLITOWI	UMD
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			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death		
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	Funeral		5. Social Security Number 6. Sex 1219-12-5987 1⊠ M 2		In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign Country)		
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yla	should be filed and Mental Hyg s marked other umatic event, t	잍	Frederick Eckes					Jrsula Ka				
, Maryland	2 s is is		19a. Informant's Name/Relationship (Type. Print) Mrs. Roberta A. Eckes (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 Starmount Lane Timonium, Maryland 210									
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E E E	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other t once.		21. Signature of Funeral Service Licensee		70	22. Name and Address Duda-Ruc	ss of Facility ck Funeral se Ave. I					
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	To the To the Comple	Me	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed (Mo	nth, Day, Year)		
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	140		30. Name and address of person who completed the second se	ed eatise of deat	th (Item 23a) (Type	e, Print)	BATTO 1	w 21	1237			
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	arts.						
-			LESS A		ST.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Amend 20b, perFH, g873, 11/8/07 TT Certificate of Death 35722 2. Date of Death 1. Decedent's Name (First, Middle, Last) Nov 2, 2007 **Physician** Alice Foley 11:11 A M Marie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Counfy of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $^{8.~\text{Date of Birth}}_{\textit{(Month, Day,}}$ $^{\text{Nov}}11$, 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2√X 1930 577 38 7610 76 Washington DC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 □Yes 2 No Directo Maryland Prince George's Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6100 Arbroath Drive 20735 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 € No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White 3 Widowed 4 Divorced Completed Department of Heatth and Mental Hygiene, important: If Item 27 is marked other than "natur any Injury or other traumatic event, the <u>Medical.</u> any Injury or other traumatic event, the <u>Medical.</u> 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretaria1 Insurance Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur I. Clarkson Lillian Gaylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Arthur W. Foley (Son) 6100 Arbroath Drive, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Durial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery Nov 11, 2007 Suitland, MD 4 ☐ Donation_ _5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service 04 |Alexandria Ferry Road, Clinton, MD 20735 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter ne disea, shock, or la art fail re Approximate Interval Between Onset and Death Immediate Care (Fin disease or condition resulting in death) Anterior Myocardial Infarction 3 Days **Physician** /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to finitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE been signed by the attendin should be detached for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nnknown <u>Diabetes Mellitas</u> Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an certificate has t irector, page 2 s autopsy performed 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 🕅 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: filled in by the 24 hours after deat e Funeral Director:

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) un D25080 Nov 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank Gravino 10313 Georgia Ave. #306 Silver Spring, MD 20902

State Registrar 31. Date filed (Month, Day, Year)

NOV 0 7 2007

82. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November FURLONG 7:32 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 28 1936 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Maryland 220-68-7340 71 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show r 28a-f shov notified at 1 Yes 2 No Md. Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or "natural", or items 23a 3837 Brooklyn Ave. 21225 Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 \$ Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker own home permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, <u>the</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Herbert Frank Mildred George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Audrey Simmons (daughter) 3837 Brooklyn Ave. Baltimore, Md. 21225 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 11/6/07 Baltimore, Md. 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licenses Ritchie Hgwy. Balto. Md. 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of) less than 24 Examiner ACUTE MYOCAR PLAL INFARCTION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ess than 24 ACUTE REVAL

Due to (or as a consequence of): certificate be executed and Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by CONGESTIVE HEART FAILURE, EMPHYSEMA, ANDMIA 2 No 3 Probably 4 Unknown RHEUMATOID ARTHRITIS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate | Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 200 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 은 1 ☐ Yes 2 ER/Outpatient 3 DOA this 27. Manner of Cath Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter t Certification: 5 ☐ Pending investigation Injury 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the date and place and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-001 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARBOR HOSPITAL, 3000 S. HANOVER ST SINGH LONG, N.D. 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygier 007For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Doris P Finnegan November 3 2007 6:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Franklin Woods Baltimore County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea December 27 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1928 Baltimore, Maryland 1 □ M 2 □ F 217 24 2555 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location If item 27 is marked other then "netural", or items 23e or 28e-f show or other treumetic event, the Medical Examination must be multipled at 1XXYes 2 □ No Baltimore Director Maryland Baltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 3707 Springwood Avenue Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ≥ 2\(\frac{2}{3}\) No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then '9 my injury or other treumetic event, the Me any injury or other treumetic event, the Me any injury or other treumetic event, the Me any injury or other treumetic event, the Me any injury or other treumetic event, the Me Elementary/Secondary (0-12) Nursing Home Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ethel Sue Finnegan Shaw Radcliffe ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21236 9327 Seven Courts Drive Karen Lanehardt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley mem. Gdns. Nov. 7 2007 Baltimore, Maryland 4 □Donation 5 □ Other (Specify) of Funeral Service Licensee 21. Signatur 22. Name and Address of Facility Lassahn Funeral Home Inc 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastation disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed should be detached for use as the burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 TYes 2 🗆 No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? (es 2 No certificate 2 No 1 TYes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 ER/Outpatient Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 TYes 2 0No 1 🗀 Inpatient 3 DOA Medical Certification: To After this Manner of Death
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Control 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 TYes 2 No investigation Director: completely filled in by the 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier am dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Ropad Glen Parmie MD 21061 OB KWOO'D Jude Muneses JB42 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

21215-0036

Baltimore, Maryland

Division or Vital Records, P.O. Box 68760.

State Registrar

DR MINUS

31. Date filed (Month, Day, Year)

NOV 0

Square DR

BalTIMORE

9000 FRANKLIN

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vasiuades

07-08535
Tony William Green

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Physician			1		Reg. 2. Date of Death		3. Time of Death
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_ G 5 5 5 F	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Stre	et and Number or i	Rural Route Number	er, City or Town, Stat	e, Zip Code)
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ox 68760, and certificate be attending physici or use as the buri	##23a, 27, 20a IF FEMALE: 23b. Was decedent pregnant in the	e of pregnancy				23d. Date of delive	•
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Division Of the Hospital or Attentwithin 24 hours after death To the Funeral Director: Completely filled in by the		knowledge, death oc			due to the cause	(s) and manner as st	ated.
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examiner and manner stated.	nination and/or investi					
2	29b. Signature and title of certifier			se number .M.E.	1	29d. Date signed (M November 3, 20	
	30. Name and address of person who completed cause of de	eath (Item 23a)	5.0				
Ø	Margarita Korell MD. Assistant Medical		Penn Street, E	Baltimore, MD	21201		
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.6			1. Decedent's Name (First, Middle, Last)	TOTAMOUTO OF	Doutin	2. Date of Dea	ath	3. Time of Death	
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ХОЯ	eath certific attending p for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death	3 ☐Ectopic pregnanc	су			of delivery th Day Year	
O.	ie dea the at hed fo	Physician/Me	in the past 12 months? 1	5 ☐ Other (specify) _			Month Day Year		
7.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in ti	ne underlying cause gi	iven in Part I.	23e. Did to	obacco use contri	bute to the cause of death?	
Vital Records,	uires signe id be	d by	A-File HTN Demention			1 🗆 Y	Yes 2 No	3 ☐ Probably ¥☐Unknown	
Ö	w req	lete				24a. Was a	an 24b. W	Vere autopsy findings available	
e T	The la te has age 2	Completed					osy promed2/ de	rior to completion of cause of eath? □Yes ೪☑No	
		Be C	25. Was case referred to medical		26. Place of	1 Yes f Death (Check only o	V		
_	£ 1 1 2	To E	examiner? 1 Yes 22 No Hospital: 1 Inpatient 2 ER/Outp	atient 3 DOA		ing Home 5 ☐ Resid	dence 6 □Othe	r (Specify)	
n or	ttending Phys leath. tor: After this of the funeral dir		27. Manyer of Death 28a. Date of Injury 28b. Tir 1 Natural 5 ☐ Pending (Month, Day Year) Inju	ury Wo			now injury occurre	ed	
IVISION	ttend death.	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, farm]Yes 2 □ No		Street and Numbe	er or Rural Route Number.	
2	To the Hospital or Attending Powitin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	4 Homicide determined building, etc. (Specify)	, street, factory, office	,	City or Tox		To Hural House Walliber,	
	ospita hours ineral y filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check only 2 Medical Examiner: On the basis of examination and)	death occurred at the	time, date and	place, and due to the	cause(s) and mar	nner as stated.	
	the Ho lin 24 the Fu	edical	one) and manner stated.						
	To To To To	Ž	29b. Signature and title of certifier	29c. Licen	se number		29d. Date signed	(Month, Day, Year)	
)			►Mg MA	0	4443		11-0	6-07 MD21301	
	7		30. Name and address of person who completed cause of death (Item 23a) (T	/pe, Print)	+ +20	& Baltin	2000	MD21301	
	Sta	ite	31 Date filed (Month Day, Year) 32 Segistrar's Signature	~ guren	7 " 50	o, mu	vune,	V- (0 4 3 1 1 1 1	
	Registi		NOV 0 7 2007 18	digital 8					

ORIGINAL

DHMH 17 Rev 1/2001

		•	For State Registrar	State	of Mary		artment of H rtificate of I			1ental Hy	giene Reg. No	000	357	28
r	Physici	an	1. Decedent's Name (First, Midd	lle, Last)		-				2. Date of De Month	eath Da	ay Year	3. Time of De	eath
1 35	/Medic		Xiangqun Gao							10-31	-200	7	131 A	М
	Examin	er	4a. Facility Name (If not institution Stella Maris	n, give street and n	umber)			4b. City, Town, or Location of Death		1		c. County of Dea		
			5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	Towson If Under 1 Year	If Under	24 Hrs.	8. Date of Bi	rth	Baltimo	re thplace (State or F	oreian
B	Funeral Director		219-57-2294	1 X M 2□ F		5.5 Yrs.	Months Days	Hours	Min.	8. Date of Bi (Month, Da 03-19-	ay, Year 1 95 2		hina	oreign
	70		Usual Residence of Decedent				<u> </u>	L	L					
	show	_	10a. State 10b. County		100	c. City, Town or Lo	cation						10d. Inside City I	_
	Ba-f s	Director		ford		Joppa								7140
	vith th	Dir	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of What C	ountry?	
	s 23g	eral	221 Spry Isla		cedent Ever	in II S 12 1	21085 Was Decedent of H		rigin? (Sp.	ooify Voc or N		weden 14. Race - Am	erican Indian	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	Armed F	orces? 2 X INo aive		If Yes, specify Cuba	an, Mexica Specify	ın, Puerto	Rican, etc.)		Black, Whi		
9	2 hou	ted	15. Decede	nt's Education		16a. Dece	dent's Usual Occup	ation	-4 -4	t	16b. k	Kind of Business		
21215-0036	I within 7 jiene. r than "n the Medi	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		kind of work done of DO NOT use retired	during mo: d)	st of work	ing	Ph	armocol	ogy	
פ	al Hyg	Be C	17. Father's Name (First, Middle	, Last)				18. Moth	er's Nam	e (First, Middle	e, Maidei	n Surname)		
ylaı	Ments Ments arked atic e	၉	Ting Long Gao					Shu	Mei	Wang				
Maryland	2 sho		19a. Informant's Name/Relation Lilli Lu	ship (Type. Print)			ng Address (Street						Zip Code)	
e,	1 and Health Sm 27 ther t		20a. Method of Disposition		12	0b. Place of Dispo	Spry Isla	and K		ppa, MI Date		085 ocation - City o	Town State	
יסר	nt of h		1 ☐ Burial 2 X Cremation		n Stata	cemetery, crei	natory or other place rematory		1-2-			_		
Baltimore,	artme artme ortani injury		4 ☐ Donation 5 ☐ Other (21. Signature of Funeral Service				2. Name and Addre	i			1	-	Maryland	
Ba	permi Depar Impor any ir		1 Tapes	ا صنعه	Sin	Ken I	nc. 610 V	W. Ma	cPha	il Rd E	3el <i>A</i>	Air, MD	21014	.1r
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that it only one cause on	each line.	death. Do not ent	er the mode of dyir	ng, such a	s cardiac	or respiratory a	arrest,		Approximate Interval Betwe Onset and Dea	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.	ON CAN									
	Examiner			Due to	o (or as a co	nsequence of):								
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	o (or as a co	nsequence of):								
	od d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	S .										
oʻ	e exec an an irial-tr	Ä	resulting in death) Last	Due to	o (or as a co	nsequence of):								
68760,	cate be executed physician and the burial-transit	dical		d										
	certific ding p	/Mec	IF FEMALE:	23c. If yes, o	utcome of p	rognanov								
.O. Box	that the death certificed by the attending podetached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live	birth 2 🗆 gnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	y				23d. Date of de Month	Day Ye	ar
Δ.	that the poly detail		Part II. Other significant condit	ions contributing to	death but no	t resulting in the u	nderlying cause giv	en in Part	1.	23e. Did	tobacco	use contribute	o the cause of dea	ıth?
rds	The law requires that tte has been signed b age 2 should be deta	Completed by								1 🗆	Yes 2	2 No 3 F	robably 4 💢 Unl	known
000	aw re- s bee	olete								24a. Wa		24b. Were a	utopsy findings av	ailable
Ä	The law cate has I	l mo								auto perl 1∐ Yes	opsy formed? 2 X 1 N	death?		se or
ita	rysician; Th nis certificate director, pag	Be C	25. Was case referred to medic examiner?	al				26. Plac	e of Deat	h (Check only				
<u>z</u> <	di is	일	1 ☐ Yes 2 ▼ No			2 ER/Outpatier		4 🗆 🛚 19	lursing Ho				ecify) HOSPI	CE_
n o	After t	on:	27. Manner of Death 1 Natural 5 ☐ Pend	ng (Mo	e of Injury onth, Day Ye	ar) 28b. Time o	Wor		701.	28d. Describe	how inju	ury occurred		
Sio	Attending r death. ector: After oy the fune	cati	2 Accident inves	I not be	o of injury	At home, farm, str		Yes 2]NO	29f Location	(Stroot o	and Number or F	Jum I Pouto Numbe	
Division or Vital Records,	after of Direct In by	Certification:	4 ☐ Homicide deter	mined 206. Flai	ding, etc. (S	pecify)	eet, factory, office			City or To	own, Sta	te)	iural Route Numbe	7f ₁
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certify	ing Physician: To t	ne best of m	y knowledge, deat	h occurred at the ti	me, date a	and place,	and due to the	e cause(s) and manner a	as stated.	
	le Ho 124 h 1e Fu	Medical	(Check only 2 Medica one)	I Examiner: On the and ma	basis of exa inner stated.		vestigation, in my o	opinion, de	eath occui	rred at the time	e, date a	nd place, and du	e to the cause(s)	
	withir To the Comp	M	29b. Signature and title of certif	er			29c. Licens				29d. D	ate signed (Mor	nth, Day, Year)	
	-							43-	125			10/31	107	
(D		30. Name and address of perso	n who completed ca	use of death	(Item 23a) (Type,	Print)							
			DR. TARIQ MAH		DULA	NEY VALL	EY RD. I	CIMON	IUM,	MD 210	93			
	Sta Registi		31. Date filed (Month, Day, Yea.	2007	Med a	Signature	E)							

1:31 a.m.

OCTOBER 31, 2007

XIANGQUN GAO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Day Physician 5 Ronald Lee Gray Jr. 200 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town Location of Death Examiner If Under 1 Year Date of Birth (Month, Day, Year) Age (In vrs. last birthday Number Funeral Days Months Hours **1**√ M 2 □ F 220-02-9912 38 April21,1969 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d, Inside City Limits 10b. County show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 257 No MD Baltimore Director Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2217 Firethorn Road 21220 USA Funeral ral", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 2X No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Saltimore, Maryland 21215-0036 Specify Specify: White þ 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrican Amtrak 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ronald L. Gray Sr. ٩ Linda Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once, Lisa Gray / wife 2217 Firethorn Road Balto. MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 11/9/07 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signat of Funeral Service Licenses 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumonia /Medical Due to (or as a consequence of): Examiner ancreatie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed nomia to (or as a consequence of): burial-tran Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 🗌 Yes No 3 ☐ Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Natural 5 ☐ Pending investigation 1 Tyes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, וה Hospies ב n 24 hours after death. the Funeral Director: Af within 24

> State Registrar

(Check only one)

29b. Signature and title of certifier

Robert

31. Date filed (Month, Day,

a

29c. License number

29d. Date signed (Month, Day, Year)

Prive Baltimore Maryland 21237

and manner stated.

-ranklin

32. Registrar's Signature

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Physician** /Medical Examine

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once.

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

2

Examiner

Completed by Physician/Medical

Be

2

Certification:

Medical

ELI

10a. State

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

attending physician and for use as the burial-transit The law requires that the death certificate be executed signed by the a Id be detached for To the Hospital or Attending Physician: r this certifica

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did
	1

26. Place of Death (Check only one)

25. Was case referred to me examiner?	dical
1 Yes 2₽ No	
27 Manne of Death	

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

٠		
	29a.	Certifier
		(Check only
		one)

1- Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

	one)			Medical	١
29b.	Signature	amid	title	of certifie	r

IASNEEM.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

asussi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAED MD 31209

State Registrar

LAKITANI 31. Date filed (Month, Day, Year)

NOV 0 7

2835 32. Signature

1 🔲 Inpatient

ORIGINAL

			For State Registrar	State of Man		artment of H	Death	Reg	2007	35731	
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Lawrence Herbert J	ones				2. Date of Death Month CLODer 3	1 ^{Day} 2007 ^{eer}	3. Time of Death 9:30 A M	
	Examir		4a. Facility Name (If not institution, give s 4445 Ebenezer Road	treet and number)	<u>-</u>	4b. City, Town, or Balti		-	4c. County of Dea		
	Funeral Director		210 01 2300 21	M 2□ F 7. Age (II	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, Y Dec. 26.		rthplace (State or Foreign ountry) nsylvania	
	e Maryland ta-f show	tor	Usual Residence of Decedent		oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2√ No	
	with the a or 28a	Direc	10e. Street and Number 4445 Ebenezer Road		3042	10f. Zip Code 2123		10g	. Citizen of What C	ountry?	
36	within 72 hours after death with the Maryland sne. than "natural", or itams 23e or 28e-1 show to Mudical Exprinter; wat be netitived at	by Funeral Director	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Eve Armed Forces? 1 Tyes 2 No If Yes, Give	044	Was Decedent of Hi	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Am Black, Wh	ite, etc.	
21215-0036	thin 72 hour e. en "natural" LMsJIGH Ex	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	946 16a. Dece	dent's Usual Occupa kind of work done o DO NOT use retired,	turing most of working	9	s/Industry Communication		
	ld be filed wi ental Hyglen ked other th ic evant, the	To Be Con	12 17. Father's Name (First, Middle, Last) Lawrence Leroy Jone	ng.	18. Mother's Name		•				
Baltimore, Maryland			19a. Informant's Name/Relationship (Typ. Dennis J. Jones (sc 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	on)	215 W 20b. Place of Disponsional Commetery, cree	. Birchwo	od Ave., I	Route Number, C Hinsdale te 20	City or Town, State,	s 60521 r Town, State	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service License				r Road, No			5.11	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. END ST Due to (or as a co	165 REConsequence of):	UMZ DIS	これらど			Approximate Interval Between Onset and Death	
8760,	death certificate be executed to attending physician and for use as the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a confirmation of the confirmati	onsequence of):	mine Di		ira Gi	went	Iwan	
P.O. Box 6	death certifi e attending I ed for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 9 \(\subseteq \text{Unknown} \)	Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month							
ecords, P.	98 90 90	ed by Pr	Part II. Other significant conditions con	A	ot resulting in the u					to the cause of death? Probably 4 Unknown	
α	The ate h page	Completed	CANTIONYOPATA CONGESTIVE IT		LONE			24a. Was an autopsy performs	prior to		
Division of Vital	or Attending Physician: The after death. Director: After this certificate ha in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 40 H 27. Manner of Death 1 Autural 5 Pending investigation 3 Suicide 6 Could not be determined	ospital: 1 Inpatient 28a. Date of Injury (Month, Day You 28e. Place of Injury building, etc. (A	- At home, farm, str	f 28c. Injury Work M 1 🗆 Y	y at 26 (? Yes 2 □ No	e 5 > esiden	et and Number or F	ecify) Rural Route Number,	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical Ce	29a. Certifier 1 Certifying Physical Certification Physical Certifica	sician: To the best of n ner: On the basis of ex and manner stated	amination and/or in	n occurred at the tim vestigation, in my or	ne, date and place, ar pinion, death occurre	nd due to the cau d at the time, date	se(s) and manner a e and place, and du	as stated. ue to the cause(s)	
ı	Tota withi Tota	Σ	29b. Signature and title of certifier	A.DI	5.5		onumber 0028512	290	I. Date signed (Mor	nth, Day, Year)	
	2	†a-	30. Name and address of person who co	mpleted cause of deat	Towson	Med . A	Issociati	es, uc	Touso.	n Md. 21204	
	Sta Registi		NOV 0 7 2007	Marine A	. Aparle	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death **Physician** /Medical Town, or Location of Death 4c. County of Death Examiner Date of Birth **Funeral** 1 M 2 F Days Hours Min. Director with the Maryland show 10d. Inside City Limits Department of Health and Mental Hygiene. Important: "or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 1 TYes 2 No 10g. Citizen of What Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after Hygiene. 1 Yes 2 If Yes, Give Year or Dates: 1. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working condary (0-12) Gollege (4-4or 5+) Father's Name (First, Midble ast) Be Pages 1 and 2 should be 20a. Method of Disposition 2 Cremation 1 D Burial 3 Removal from State 5 Other (Specify) 4 Donation of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ANCINO disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-tran Due to (or as a consequence of) Box 687605 physiclan Physician/Medical that the death certificate the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Day Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9□ Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s 24a. Was an certificate has autopsy performe Division or Vital 1☐ Yes 2 No Physiclan: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 🗌 Yes 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) me and addr 6

ORIGINAL

State Registrar Year)

DHMH 17 Rev 1/2001

			For State Registrar		State	of Marylai		artmen			and M		giene Reg. No.	0 0 0	7	25	723
	Physici	an	Decedent's Name (First, Mi	ddle, Last)							2. Date of De Month	ath Day	/ Ye	ear 3	3. Time of	Death
-	/Medic	al -	ILONA 4a. Facility Name (If not institu	tian nive				4h City	KANN	Location of		DCTOBER	26	2007 County of D		1:00	P M
	Examin	er	2506 LARRYV			rriber)		1	TIMC		Deain			ALTIM		CTTV	
	Funeral Director		5. Social Security Number N/A	6. Se			. las <i>t birthd</i> ay) 91 Yrs.	1			24 Hrs. Min.	8. Date of Bir 02/16/	th	9.		e (State o	or Foreign
	and ww		Usual Residence of Decedent 10a. State 10b. Cou	nty		10c. C	ity, Town or Lo	ocation							10d.	Inside C	ity Limits
	Maryl a-f sho fied a	tor	N/A I	I/A		T(ORONTO,	CANA	DA							1 Yes	2 □ No
	or 28s	Funeral Director	10e. Street and Number	0.4.0				10f. Zip		10			10g. Citi	zen of Wha		?	
	eath w	eral	17 MIDVALE 1	KUAD	12. Was Dec	edent Ever in l	IS 13.		SH 3F		gin? (Sn	ecify Yes or No		CANA		Indian.	
9	or Iten	Fun	1 Never Married 2 N	arried	Armed F	orces? 2 7 No ive X		If Yes, spe 1 ☐ Yes		n, Mexicar Specify:		ecify Yes or No Rican, etc.)			White, etc.	HITE	
2-0036	hours tural",	d by	3 Widowed 4 □ Divor		Year or I	Dates:		dent's Usu					16h K	Specify:			
215	hin 72 e. In "nat Medic	plete	15. Dece (Specify only high Elementary/Secondary (0-1.	hest grad	ie completed,	(1-4or 5+)	(Give	kind of wo DO NOT u	rk done d	during mos	t of work	ing				ou y	
2	be filed within 72 hours after death with the Maryland ttal Hygiene. ad other than "natural", or Items 23a or 28a-f show event, the Medir-al Examiner must be notified at	Completed by	12		- College (HOMEM	IAKER		40.14.15		- (Fine A 4) (-1)		WN HO	ME		
Maryland	ed all all all all all all all all all al	To Be	17. Father's Name (First, Mide MICHAEL	le, Last)			MAYE	:R		ROSI		e (First, Middle	, Maiden		HALPE	ERT	
ary	s 1 and 2 should by f Health and Ments item 27 is marked other traumatic ev	۲	19a. Informant's Name/Relati	nship (T)			19b. Maili	ng Address	(Street	and Numbe	er or Rur	al Route Numb	er, City c	or Town, Sta	te, Zip Co	ode)	
	1 and 1 Health Sm 27 ther tr		MARTHA VIDA 20a. Method of Disposition	ER /	DAUGH		Place of Dispo			LE RO		- BALTI Date		, MD			
nor	00		1 ☑ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Othe			State BAT	cemetery, cre [HURST	matory or c LAWN -	CLAN	TON 1	10/29	9/2007		ONTO.			
Baitimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Serv			PAI	RK SYNA	2. Name ar	nd Addres	ss of Facili	ty St	OL LEVI	NSON	& BR	05	INC.	
<u> </u>	8 3 E 6 8		- Kay VV	· U	ttta			8900	REIS	STERS	TOWN	ROAD -	PIK		LE. N	MD 21	208
E	Physician		23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition	or comp ist only o		caused the dea each line. SCULAR	Care County in the San San San San		le of dyin	ig, such as	cardiac	or respiratory a	rrest,		In	pproximaterval Betterval Betterval Better and Section 1 1 1 1 1 1 1 1 1 1	tween Death
	/Medical Examiner		resulting in death)		Due to	(or as a conse	quence of):										
		ner	Sequentially list conditions, if any, leading to immediate	J	b. Due to	(or as a conse	quence of):								+		
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		C	(or as a conse	cuanca of):										
760,	sician burial	cal E	3 ,	•	d.	(or as a conse	quence oi).										
9	rtificate ng physi as the		IE EENAN E.	_	u												
.O. Box	he death certifica the attending ph ched for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		1 ☐ Live	utcome pf pregr birth 2 □ Fe nant at time of nown	etal death 3 ☐Ectopic pregnancy					23d. Date o Month			,	зу	Year
О.	w requires that the d been signed by the should be detached	y Ph	Part II. Other significant con	ditions co	ntributing to	death but not re	sulting in the u	ınderlying d	ause giv	en in Part I	,	23e. Did	tobacco	use contribu	ite to the	cause of	death?
ords	equire sen sig ould b											1 🗆	Yes 2	No 3[Probab	ly 4 🗆	Unknown
l Records,	The lay ate has page 2	Completed										24a. Was auto perfi 1□ Yes		prio	re autopsy r to compl th? Yes 2[letion of o	available cause of
Vital	Physician: Th r this certificate eral director, pag	Be	25. Was case referred to med examiner?	-	Hospital: , _				Oth	OF.		h (Check only	one)		IGHTE	- PS -	IOUSE
	y Phys er this eral dii	1: To	1 ☐ Yes 2 ☐ No 27, Manner of Death		28a. Date	Inpatient 2	28b. Time of		28c. Injur Worl	4 🗆 140	ursing Ho	ome 5 Res 28d. Describe		6 XIOmer ry occurred	Specify)	-11.5	,000E
NO.	ath. or: After he funera	ation	Z C Accident	stigation	(Mo	nth, Day Year)	Injury	М		k? Yes 2 ☐	No						
Division or	al or Att	Certification:		ild not be ermined		e of injury - At l ding, etc. (Spec		reet, factor	y, office			28f. Location (City or To			or Rural A	Route Nur	nber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification and the funeral Director. After this certification in by the funeral director, the funeral director.	Medical C	29a. Certifier 1 Certi (Check only 2 Medi	rying Phy cal Exam	iner: On the	e best of my kr basis of examir nner stated.	nowledge, dea nation and/or i	th occurred	at the tir	me, date ar opinion, dea	nd place, ath occur	and due to the	cause(s , date an) and mann d place, and	er as state d due to th	ed. ne cause((s)
	To the within To the comple	ž	29b. Signature and title of cer	ifier			·/			e number				te signed (/			
)	~		- Can	non	20-/	nh	2.00		2555	9			OCTO!	BER 26	. 20	07	
	3		30. Name and address of per LAWRENCE VIDA			ise of death (Ite 06 LARR)			кді ті	MORF	MD	21209					
	Sta		31. Date filed (Month, Day, Yo	ar)		Registrar's Sign	nature		ZCIET I	-1101/ L	שויו פ	C1507					
	Registr	ar	NOV 0 7	2007	J. Select	RI SS	Spark	م									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month **Physician** ARNOLD **KLAPPER** NOVEMBER 2007 9:24 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4730 ATRIUM COURT OWINGS MILLS BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/22/1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F 132-01-8624 88 **POLAND** Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at another. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 ATRIUM COURT #528 21117 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?
1 X Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify WHITE Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **JEWELER JEWELRY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OSCAR KLAPPER MIRIAM LOSCH 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDITH KLAPPER / WIFE 4730 ATRIUM COURT #528 - OWINGS MILLS, MD 21117
ce of Disposition (Name of Date 20c, Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State ANSHE EMINAH CHAIM CONG. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/05/2007 BALTIMORE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS.. INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pays disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cace (Disease of Injury) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s certificate has autopsy 2 ☐ No 1□ Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 ☐ D**O**A မ 1 ☐ Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title On 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTOMA

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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2700

32. Feristrar's Signature

MACINON

31. Date filed (Month, Day, Year)

		-	1 - For Amend Item 29d per dr., 2873, II	artment of Health and Men 07.707dhb rtificate of Death	tal Hygiene Reg. No. 2007	35735
1965	Physicia	an	Decedent's Name (First, Middle, Last) MIKHAIL	2.1	Date of Death Month Day Year TOBER 29 2007	3. Time of Death 5:30A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deat	h
n/ii	Funeral		JEWISH CONVALESCENT CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	BALTIMORE If Under 1 Year If Under 24 Hrs. 8.1 Months Days Hours Min.	Date of Birth 9 Birth	hplace (State or Foreign
	Director		220-21-0299	09	Month, Day, Year) Co / 27/1915 U	KRAINE
	with the Maryland a or 28a-f show be notified at	ō	10a. State 10b. County 10c. City, Town or Low MD BALTIMORE BAL	TIMORE		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28a-	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	•
	ns 23a must k	Funeral	6918 MARSUE DRIVE APT. 1-A 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21215 Was Decedent of Hispanic Origin? (Specity If Yes, specify Cuban, Mexican, Puerto Rice	U.S.A Yes or No- 14. Race - Ame	rican Indian,
36	within 72 hours after death with the Maryland Jiene. I then "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Fur	1 Discouling and OD Marriage 1 DVoc 2 DNo	If Yes, specify Cuban, Mexican, Puerto Hica 1 ☐ Yes 2 ☐ No Specify:	un, etc.) Black, White Specify:	e, etc. WHITE
15-003	within 72 hou ene. than "natura he Medic I E	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/	Industry
212	filed withi Hygiene. other thar ent, the N	Comp		NICAL ENGINEER	FACTORY	
land	be d od od	To Be	17. Father's Name (<i>First, Middle, Last</i>) JOSEPH KUPERST	'	rst, Middle, Maiden Surname) PECHERSK	AYA
altimore, Maryland	12 s har 7 is trau		, , , ,	ng Address (Street and Number or Rural R		Zip Code)
	Heal Heal tem 2		20a Mathed of Disposition 20b Place of Disp	FREGARONE ROAD - TIM position (Name of pate) G. 10/30/2	20c. Location - City or	Town, State
	permit. Pages Department of Important: If it any Injury or once.				LEVINSON & BROS	INC.
Ä	Imp Beny any		110000	8900 REISTERSTOWN RO		
I	Physician	8 8	23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		spiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of): CELCS(Constant)	,	10	5 × 200
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- State in the		
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Box	uires that the death certifica signed by the attending ph d be detached for use as th	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of de Month	livery Day Year
o	at the de by the a	hysic	9 Unknown 9 Unknown			
Records, P.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death?
3eco	ne law requir has been si ge 2 should	Completed				utopsy findings available completion of cause of
		Be Co	25. Was case referred to medical examiner?	26. Place of Death (C	1□ Yes 2 No 1 □ Yes	
or Vital	<u>a</u> ∓ <u>a</u>	은	1 ☐ Yes 2 ☐ Yeo ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death		5 ☐ Residence 6 ☐ Other (Specific Lines of the Control of the Con	ecify)
Division	Attending Phyrdeath. ector: After thi	Certification:	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury - At home, farm, s	M 1 ☐ Yes 2 ☐ No	(0)	
Divi	Hospital or Atten 44 hours after death Funeral Director: tely filled in by the	Sertifi	3 Suicide 4 Homicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f	Location (Street and Number or F City or Town, State)	tural Houte Number,
	an (V an (D)	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal of the control of the	nvestigation, in my opinion, death occurred	at the time, date and place, and du	is stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	
	(7)		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	November (
		ate	July January January 131. Date filed (Month, Day, Year) 32. Registrar's Signature	29c. License number DNO39 Print Avenue	BARTIO	7(209
	Regist	ate rar	NOV 0 7 2007 / / / /			

DHMH 17 Rev 1/2001

			For State	State	of Mary	•	artment of H		Mental Hygi	ene	7.0	35736	
			1- State Registrar Certificate of Death Reg. No. 200								101		
	Physicia	Decedent's Name (First, Middle, Last) Vicinian					- 3		2. Date of Death Month	n Day	Year	3. Time of Death	
	/Medical Larry Curtis				Curtis	Lundy		October	31, 2	007	9:30 A M		
	Examin	er	4a. Facility Name (If not institution	, give street and no	umber)		4b. City, Town, or	r Location of Death		4c. County	y of Death		
			8415 Kavanag	h Road			1	Dundalk		Bal	timor	е	
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp Coun	lace (State or Foreign	
	Director		219-50-0322	1 ⊠ M 2□F	57	Yrs.	World Buye		May 23,			land	
П	pu ,		Usual Residence of Decedent 10a. State 10b. County		10	c. City, Town or Lo	action				1	0d. Inside City Limits	
	anyla shov d at	_	10a. State 10b. County		100	c. Oity, Town of Lo	CallOIT				'	1 □Yes 2 XNo	
	Ba-f	5		timore_	imore				Dundalk				
	or 2	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of	What Cour	ntry?	
	23a ust b		8415 Kavana	gh Road				21222		United			
	ems	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span. Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - Americ ck, White,		
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$\frac{3}{2}$	ours iral",	d by	3 ☐ Widowed 4 1 Divorced	Year or	Dates:						Į.	Mite	
5	72 h 'natu dic	Completed	15. Decedent (Specify only highest	's Education at grade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	king	16b. Kind of E	Business/Inc	dustry	
7	ithin ran "	ldu	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT use retired	d)					
7	ed w ygier yer th	Ö	12 Years			Waste	Managem			Balti		City	
2	al H	Be	17. Father's Name (First, Middle,	Last)					ne (First, Middle, N		me)		
2	Meni Meni arked	ဥ	Hugh C. Lund	У				Elsie	E. Laws	on			
<u> </u>	and aum		19a. Informant's Name/Relations				ng Address (Street			-		· ·	
,	s 1 and 2 should be filed within 72 hours after death with the Manyland if Health and Mental Hygiene. If Health and Mental Hygiene, and Tris marked other than "naturaly, or items 23a or 28a-f show ther traumatic event, the Medic. I Examiner must be notified at other traumatic event,		Maurnitta Rey	nolds (Co			31 Park H						
ב כ	of H of H f iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	n state	Ob. Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date 2	20c. Location	- City or To	own, State	
	Pag nent ant: I		4 Domation Other (S			Mezdowri	idge Mem.	Park 11,	/3/2007	Dorsey	, Mar	yland	
Ē	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai		21. Signature of oneral Syrvice	Ligaryo X	///	// 2	2. Name and Addre	ss of Facility	Home of	Dundal	k Tr)C	
ם	e a T E		mal 1	11/1	2/1		7922 Wise						
	. 9		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the	death. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory arre	est,		Approximate Interval Between Onset and Death	
	Physician	0	Immediate Cause (Final disease or condition	N	Neovo III	almod.	- Cond	buas cu	las Die	eas	9	Onset and Death	
	/Medical		resulting in death)	a. Due to	o (or as a co	nsequence of):	c cerci	ours eu	00000				
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1	unted d ansit	Examiner	Cause (Disease or injury that initiated events										
, ה	exec in an ial-tr	Exa	resulting in death) Last	Due to	o (or as a co	nsequence of):							
50	The law requires that the death certificate be executed ate has been signed by the aftending physician and page 2 should be detached for use as the burial-transit	dical		d									
0	tificat g phy as th	edi		1									
5	death certifica aftending ph for use as t	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o			7			23d. D	ate of deliv	ery	
	death afte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	gnant at tim		⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		M	fonth	Day Year	
į	w requires that the d been signed by the should be detached	hysician/Me	9 □ Unknown	9□Unk	nown								
Ţ.	s that ned b	Δ.	Part II. Other significant condition	ons contributing to	death but no	ot resulting in the u	inderlying cause giv	en in Part I.	23e. Did tol	nacco use co	ntribute to t	the cause of death?	
" 5	quires n sign ald be	d by							1 □ Y€	es 2 🗆 No	3 ☐ Pro	bably 4. Unknown	
3	w rec	Completed							24a. Was a	n 24b	. Were auto	opsy findings available	
ב	he la has ge 2	E G							autops perforr	ned?	prior to co death?	ompletion of cause of	
g	n: T ficat or, pa		25. Was case referred to medica	1				OC Plans of Day		2 140	1 ☐ Yes	2.0 No	
5	sicia certi	Be	examiner?	Hospital:	- Innetient	2□ED/Outpatio	nt 3000A Ott	ner:	ath (Check only on			~ .	
5	Phy r this ral di	- To	27. Man of Death		Inpatient e of Injury	2 ER/Outpatie	III 3 DOA	4 □ Nursing F	28d. Describe ho	ence 6 🗆 O		(ty)	
5	ding T. Afte fune	ion	1 Natural 5 ☐ Pendin	g (Mo	onth, Day Ye		Wo	rk? Yes 2∐No		,,			
2	tten death stor: / the	ical	3 Suicide 6 Could	not be	ce of injury -	At home farm st	reet, factory, office		28f Location /St	reet and Nun	nher or Rur	ral Route Number,	
=	or A after Direction by	Certification:	4 ☐ Homicide determ	ined bui	lding, etc. (3	Specify)	, , ,		City or Towi	n, State)			
	pital	Ö	29a. Certifier 1 ☐ Certifyir	ng Physician: To t	he hest of m	v knowledge dea	th occurred at the t	ime_date and place	e and due to the c	ause(s) and r	manner as	stated	
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filed in by the funeral director, page 2	edical		Examiner: On the		amination and/or i	nvestigation, in my						
	o the	Mec	29b. Signature and title of certifie				29c. Licens	se number	2	9d. Date sigr	ned (Month	, Day, Year)	
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			30. Name and address of name	who completed	الالمادة	n (Ilem 23a) (Type	1 7 0	866(Jovem	ner 1	1200/	
	V		30. Name and address of person	- 1 11 1	use or death			71.1	onville	MI	2.10	998	
	Sta	te	31. Date filed (Month, Day, Year)	32	Registrar's	Signature	· a-	.,	010.00	, ,		1	
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			140 4 0	9	-	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 02 ovember 00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Raltimore Cita HOPKINS NA Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7-8-1960 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 1□M 2□F 213-76-3380 Director Md. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show iral", or items 23a or 28a-f show Examiner must be notified at 1 √Yes 2 No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 645 Sterling Street 21202 USA Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. once. Black, White, etc. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Floyd Little Carrie မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte High Sister 5209 Frankford Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cem. 11-8-07 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. Part . Enter the visease, or complications that care ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shorts, or hear failure. List only one cause on each limit. Approximate Interval Between Onset and Death Immediate Cause (Final ommunity Acquired **Physician** disease or condition resulting in death) day /Medical Due to (or as a consequence or) **Examiner** hronic obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed intranasa Box 68760, Due to (or as a consequence of) burialphysician the burial Physician/Medical aftending p for use as SE IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □ Ectopic pregnancy Day 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 20 No has certificate ha Division or Vital 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending Natural 2 Accident Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 M.D. RES - 000 November 02, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chan 600 north Wolfe Street MD 31. Date filed (Month, Day, Year)

State Registrar

MOV 0 7 2007



ORIGINAL

		1	For State Registrar	State of Marylan		artment of F tificate of			giene 2007	35738	
	Physicia	an	Decedent's Name (First, Middle, Last)	ETHEL I	LUBY	ARSKY	(2. Date of Dea Month /0	127/0 Year	3. Time of Death $10.15 \text{ A} \text{ M}$	
H	/Medic Examin Funeral	er	4a. Facility Name (If not institution, give Holy Cross Nursin 5. Social Security Number 6. Security Number	g Facility	last birthday) Yrs.	4b. City, Town, of If Under 1 Year Months Days	Burtons If Under 24 Hr. Hours Min	ville s. 8. Date of Birt (Month, Da)	y, Year) C	mery rthplace (State or Foreign country)	
and	Director		059-14-3464 Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo	cation		10/1	2/1917 NY	10d. Inside City Limits	
Mac	ried fied	to	MD Montgome	ery Si	lver S	pring				1 ☐ Yes 2 M No	
the the	or 286	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?	
£.	23a		14508 Homecrest R			20906			United St		
036 urs after des	af', or iteme Examinar m	by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 2 No		Specify Yes or No erto Rican, etc.)	Specify:		
21215-0036 d within 22 hours after death with the Maryland	and Mantal Hygiene. Is marked other than "naturaf", or iteme 23a or 28e-f ehow eumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)		dent's Usual Occu kind of work done DO NOT use retire etary	during most of w	rorking	16b. Kind of Business/Industry University / College		
N t	Hygin at the		17. Father's Name (First, Middle, Last)	2		1	18. Mother's No	ame (First, Middle,	Maiden Sumame)		
<u>a</u>	rked c	To Be	David Kayton				Helen	Feldman			
Maryland	and N		19a. Informant's Name/Relationship (7)						er, City or Town, State,	Zip Code)	
2 5	m 27	1	Ellen Lubarsky/Dau		- Or a series	W. 86th	St. New	York, NY	20c. Location - City of	or Town State	
altimore,	tent: if item 27 is marked jury or other treumatic e		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Ch	cemetery, crer nesapea	matory or other pla ake Crema	tory Inc	Oct 31	Beltsville		
Bai	Department of Important: if any injury or once.		21. Signature of Funeral Service Licens	nam	02	933 Gist	ral & Ćre Ave. Sil		g, Maryland		
1	hysician /Medical		23a. Part I. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the deal ne cause on each line. a	entre		Α.	disease	rrest,	Approximate Interval Between Onset and Death	
	physicien and steepers sine burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for as a consect. Due to for as a consect. Due to for as a consect.							
Вох	igned by the attending price detached for use as fi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ™No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fete 4 Pregnant at time of o	al death 3	□Ectopic pregnan □ Other (specify) _	су		23d. Date of d Month	delivery Day Year	
ds, P.O.	n signed by	6	Part II. Other significant conditions co		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 70 3 Probably 4 Unknow						
Division of Vital Records,	certificate has been si rector, page 2 should i	Completed	Chonce Obstruct	nue Pulmone	my Dis	ease			an 24b. Were psy prior to death 1 \(\sum Y \)		
/ita	ertific ector,	Be (25. Was case referred to medical examiner?	Unanitali		10	thor /	Death Check only	-10		
of o	this o	P	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie	nt 3L DOA	4 Mursing	-	how injury occurred	pecify)	
uc	Affer funer	tou	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	W	ork? ⊒Yes 2 ⊒No				
Division	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Speci		reet, factory, office	Э		(Street and Number or wn, State)	Rural Route Number,	
	24 hours 24 hours Funeral etely filler	edical C	29a. Certifier (Grico only and) 2 Medical Exam	ysician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, dea ation and/or in	th occurred at the nvestigation, in my	time, date and pla opinion, death or	ace, and due to the courred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)	
	within To the	₩ W	29b. Signature and title of certifier		<		nse number		29d. Date signed (Mo		
	7 - 0	-	/ / / / / / / / / / / / / / / / / / /	220	-	PX	563337	-	10/291	60	
	10		30. Name and address of person who of Donothy Seay, m	2026 8	m 23a) (Type	Print) Avenue	Saite 20	3 Balt	nune, Md	21209	
e.	St Regist	ate rar	31. Date filed (Month, Day, Year) NOV 0 7 2	32. Registrar's Sign	nature	Carles					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 29,2007 5:20P Katie Rhemelle Lane Oct. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Social Security Number 6. Sex 7. Baltimore If Under 1 Year | If Under 2 24 Hrs. Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2 F Months Yrs Director 215.30.4509 72 06.10.1935 SC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County show 1 ☐ Yes 2 No a or 28a-f sh Completed by Funeral Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21228 U.S.A. items 23a 801 Winters La. Apt.432 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 ☐ Divorced Year or Dates: "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) is marked other than raumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Moselle Brown John Henry Smith ပ Item 27 is marke other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) daughter Patricia McDonald/ Mill, MD 212 1935 Winder Rd., Windsor MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 11.02.07 Landsdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) Mt. 22. Name and Address of Facility Cremation And Fueral Balto. 21. Signature of Funeral Service Licenses M01443 Alternatives 8717 Grenn Pastures Dr. MD 23a. Part1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Peath immediate Cause (Final **Physician** Small disease or condition resulting in death) DOWE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed signed by the attending physician and defeached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 nknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2₩ No 1 ☐ Yes 일 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manyer of Death 28c. Injury at Work? 1 Naturai (Month, Day Year) Injury 5 Pending

5:30pm Division or Vital Records, P.O. Box 68760, Died: 10/29/07 To the Hospital or Attending Physician: ratie R. Lane within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dil

Medical Certification: 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

College Server

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Entawit 31. Date filed (Month D 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** LATHAM BEVERLY 2007 /Medical 4c. County of Dea 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Raltimore Hospiter Samaritan Good | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, | April 17 9. Birthplace (State or Foreign Age (In yrs. last birthday, 5. Social Security Number Year. **Funeral** 1 □ M 2 12 F 68-463 50 Yrs. Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a State marked other than "natural", or Items 23a or 28a-f show matic event, the M-di-al Examiner must be notified at 1 Ves 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Wabast Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any Injury or other traumatic event Clara Noman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Rélationship (Type, Print) atham 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Fugeral Service Licensee Maryland proximate nterval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Candorecerral Physician Sudden MOREC /Medical Due to (or as a consequence of): Examiner Mont erebro if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine Hospital or Attending Physician: The law requires that the death certificate be executed henon tmboliz Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1∐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11/04

State Registrar

31. Date filed (Month, Day, Year) NOV 0 7 2007

BONIEVARA
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Boulevara

Sperk

C-EBREWOLD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Leonard B. Muchla 2007 10:30 November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis Heritage Meridian Care Ctr. Dundalk Baltimore Co. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Sex 1¥XM 2□F **Funeral** Months Days April 30,1921 Maryland Director 220-03-4680 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State r 28a-f show notified at 1 ☐ Yes 2 No Dundalk Baltimore Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ann of Health and Mental Hygiene.
Tif item 27 is marked other than "natural", or items 23a or: ury or other traumafte event, the Medical Examiner must be a 7800 St. Fabian Lane 21222 United States Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2XXXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify Specify: ģ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Industry 8 Years Longshoreman 18. Mother's Name (First, Middle, Maiden Surname)ukn. 17. Father's Name (First, Middle, Last) Be Josephine Alexander Muchla P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any Injury or other trau once. 7800 St. Fabian Lane Dundalk, Maryland 21222 Mrs. Mary E. Muchla (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □Cremation 3 □Removal from State Sacred Ht. of Jesus Cem. 11/6/2007 Dundalk, Maryland 4 □ Qonation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Division or Vital Records, P.O. Box 68760(完成 at or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 1∐ Yes 2 No certificate tal or Attending Physician: The safter death.

al Director: After this certificate ed in by the funeral director, par 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner Death 5 Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature à

State

31. Date filed (Month, Day,

Year)

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23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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RANDAUSTONN MD

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) KHW1KHW

RAVITET

31. Date filed (Month, Day, Year)

NOV 0 7 2007

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Jovember 5 Muhammad Μ. Robest /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltmore oital Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 8 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** Hours Robest Muhammac 1 ☐ M 2 💢 F 069-12-5539 20 Director 10 Usual Residence of Decedent 10c. City, Town or Location death with the Maryland 10a. State 10b. County ms 23a or 28a-f show must be notified at Baltimore Director NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 4030 Belle Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 3 any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 🔑 ☐ No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Variety Store Business Owner 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emmaline Glover Isaih Hickson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4030 Belle Ave, Baltimore, Md Wali Muhammad-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Pikesville, 11/8/07 Druid Ridge 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 3a. Part1 Enter the disease, or complication: that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of): Examiner piratory Sequentially list conditions, if any, leading to infine quate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Stage be executed and Due to (or as a consequence of): Box 68760, physician rania Physician/Medical the for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) 4☐Pregnant at time of death ed by the a detached f P.0. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ myocardia Completed 24a. Was an autopsy performed? Yes 2 No certificate has

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

23d. Date of delivery

Dav

Month

3. Time of Death

5:39 AM

Birthplace (State or Foreign Country)

SC

10d Inside City Limits

1X Yes 2 No

Year

2007

U.S.A.

Specify:

14. Race - American Indian.

Black

21215

Days

Black, White, etc.

1□ Yes 26. Place of Death (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 TYes

27. Manner of Death

1 XNatural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

2 No

5 ☐ Pending investigation

6 ☐ Could not be

determined

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sirnbaum na 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

funeral director,

this

After t

lospital or Attending Pithours after death.

within 24 hours a To the Funeral C Hospital

Be

Certification: To

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day November 5, Markovich 2007 3:20P Mary Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Cherry Lane Nursing Center Laurel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1 □ M 2**X** F Months Min. Yrs. **Director** 186-34-4184 93 March 9, 1914 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the M-dical Examiner must be notified at 1 ☐ Yes 2 No Directo Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3513 Sharonwood Road 20724 Apt 1B United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Completed by Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Ments fitem 27 is marked r other traumatic e 2 Thomas Simon Sabo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard Markovich/son Odenton, Maryland 21113 604 Crawfords Ridge Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nother (Specify) Entombment Ft. Lincoln Cemetery 11/8/2007 Brentwood, Maryland 21. Signa De of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 phinns thomas K 23a. Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Alzhiemers Disease Several Years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events. Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed signed by the attending physician and signed by the attending the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 3☐ No page 2 s 24a. Was an autopsy 1∏ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4\(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) Hospital: မှ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this nours after death.

neral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 24721 November 6, 2007

State Registrar

DHMH 17 Rev 1/2001

14333 Laurel Bowie Road Laurel, Maryland 20708

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

Syed A. Sadiq, M.D.
31. Date filed (Month, Day, Year)

NOV 0 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 23a per dr., g8/3,11/0/0/drb

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 12:34 AM Dctober 30, 2007 James Marais /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore BALTIMORE Harbor HospinaL 8. Date of Birth (Month, Day, Yea 6/15/1953 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** Hours Country) MD Days Min 1**X** M 2□ F Yrs. 54 214-66-3221 Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10h County иет ил is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifled at 1 ☐ Yes 2 ☐ No MD Anne Arundel Linthicum **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 305 Oakdale Road 21090 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🚻 No white Baltimore, Maryland 21215-0036 Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machining 12 C&C Operator 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If item 27 is marked ot any Injury or other traumatic ever Be John William Marcus Sr. Madelene Elizabeth ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 305 Oakdale Rd Linthicum MD 21090 Mr. Linda Marcus/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 11/1/2007 Stevensville, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. natu Proeral S No. 100 nee M01364 1 2nd Ave SW Glen Burnie MD 21061 Srvc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pulmonary disease or condition resulting in death) Due to (or as a consequence of) /Medical Thr. 10 mins Examiner Aspiration Preumonia HSPIRATIO Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of Examiner the burial-tran Due to (or as a consequence of): Physician/Medical as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown cancel 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No pothypoidism 24a. Was an autopsy page obstructive pulmorary disease 1□ Yes 2X No certificate Vital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ this ō 28b. Time of Injury After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD KES 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MDZ1228

State Registrar

ANGELITA 31. Date filed (Month, Day, Year)

NOV 0

3001

5 MANDUER ST.

ESMPILIA, MD

32 Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month/ Year **Physician** .3/ 200 Patricia Ruth Medinger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Square +111 140 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 7 F 67 January 26,1940 Florida Director 261-58-2901 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Director Rosedale Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21237 Funeral 8817 Trimble Way 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 Married Specify: White or. 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If item 27 Is mark a other th any injury or other traumatic event, the once. 12 should be filed w h and Mental Hygier 7 Is mark • other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia Wisenheimer John Looker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1134 St. Peter St. Indianapolis, Indiana 46203 Sara Kathleen Mellon (daughter) Baltimore, Place of Disposition (Name of cemetery, crematory or other place)
Moreland Mem. Park 11/5/2007 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Buriat 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland 22. Name and Address of Facility Schimunek 21. Signature of Funeral Service Licensee Funeral Home, Inc Buan a Weller 9705 Belair Road Nottinghame, MD 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner LINON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a detached i 9 ☐ Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ ver 2 □ No 24a. Was an autopsy performed? /es 2 \sum No hasl certificate 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes Certification: To this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After t (Month, Day Year) Injury Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ORIGINAL

9000

Franklin 32. Pegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	late of Maryland		tificate				Reg. No.	007	35747		
	hysicia	ın	1. Decedent's Name (First, Middle, Last) Anna Minerva	Montour					2. Date of Dea Month OCT.		200 ^{Year}	3. Time of Death 9:10a _M		
	/Medic		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death				4c. County				
			Eastpoint Nursi				stpo				altimo			
	ineral rector		5. Social Security Number 6. Sex 1 🗆 M	7. Age (In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Day May	4 ^{Yea} ()92	9. Birthp Coul	place (State or Foreign MD		
Maryland	be filed within 7.2 frouts after death with the wat yeard that have then "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at:	or	Usual Residence of Decedent 10a. State		Town or Loc							0d. Inside City Limits 1 ☐ Yes 2 XNo		
with the l		Funeral Director	10e. Street and Number 1046 North Poin	t Blvd.		10f. Zip	Code 2122	24		10g. Citizen	of What Cou	ntry?		
1 215-0036 within 72 hours after death with the Maryland ene.	al", or items 2 xaminer mus	by Funera	11. Marital Status 1 Never Married 2 Married 3 3 10 Nover 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1		Vas Deced Yes, spec		panic Origin? (Sp., Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Americ Black, White, ecify: Whi	etc.		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene.	han "natura e Medical E	Completed	15. Decedent's Educati (Specify only highest grade co	on <i>Impleted)</i> College (1-4or 5+)	16a. Deced (Give I life. D Home:	kind of wor OO NQT us	rk done du se retired)	tion uring most of work	ing		of Business/In	dustry		
filed v Hygie	n, th		17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle,	Maiden Sui	rname)			
yland ould be fi Mental H	c evel	o Be	William H. Hens	on				Lilli	an G.	Nise	er			
Maryla Id 2 should Ith and Men	2 sh and is m	우	19a. Informant's Name/Relationship (Type. Kenneth Minor /				,	nd Number or Ru Lane	ral Route Numb Baltim					
Pages 1 and 2	nt: If item 2 ry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State Gar	ce of Dispos metery, crem	sition (Nar natory or o n Fo	ne of other place rest	0 !	Date 5 / 0 7		ion - City or T 1gs Mi	3.475		
balti permit. Departm	Important: If it any injury or o		21. Signature of Funeral Service Licensee	Cornelly 1	1	Con	noll	of Facility 30 v Fune	ral Ho	ma of		. MD x 21221		
/Mo Exa	thy death certificate be executed by the attending physician and tached for use as the burial-transit	Completed by Physician/Medical Examiner	by Physician/Medical	by Physician/Medical	23a. Part1. Enter the disease, or Semplicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):		5					Interval Between Onset and Death
BOX of					by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknowh	If yes, outcome pf pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of decent	death 3□	Ectopic p				230	d. Date of deliver Month
dS, P.	gned be de					by	1 D Yes 2 D No. 5							
	The law requir									24a. Was auto perfe 1∐ Yes		24b. Were aut prior to c death? 1 ∐ Yes	opsy findings available ompletion of cause of	
VII	certificate rector, pag	Be	25. Was case referred to medical examiner?	nital:			Othe	26. Place of Dea						
P &	After this uneral dir	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?				lome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			ify)			
_ 0	- E E E	Certification:	Accident investigation Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
DIN the Hospital or hin 24 hours afte	To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	ian: To the best of my know r: On the basis of examinati and manner stated.	vledge, death on and/or in	h occurred evestigation	at the tim	ne, date and place pinion, death occu	e, and due to the urred at the time	cause(s) ar , date and p	nd manner as lace, and due	stated. to the cause(s)		
To th within	To th comp	Me	29b. Signature and little of certifier				c. License			- (signed (Month			
				\sim			D	2346	ک	10	3/07			
U	b		30. Name and address of person who com	1D 7840	23a) (Type,	Print)	SON 6	Rope	1 01e	en Po	omie	15018 MD		
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signat	ure	wale	9							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35748 State of Maryland / Department of Health and Mental Hygiene 17 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 OCTOBER AULER ATHY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BAYVIEW MEDICALLENTO JOHNS HOPKINS If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 01/23/1969 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Maryland 1 M 2 XF 37 unk Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 XNo Oueen Annes' Chester **Funeral Director** MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 604 Dominion Road 21619 Pages 1 and 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail 9 Cashier ilth and Mental Hygiel 27 Is marked other the r traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Juanita Crone Davis Boyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 604 Dominion Road, Chester, MD 21619 Kristina A. Mauler, Daughter Health item 27 I Department of Heal Important: If item 2 any Injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 10/25/2007 Baltimore, Maryland 4 □ Donation 5 □ Qther (Specify) 22. Name and Address of Facility 21. Signature of Funera M01113 Skarda Funeral Home 2729 Hudson Street, Baltimore, MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DIFFICILE WLITIS 9 DAYS Physician CLOSTRIDIUM /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any seal of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner spital or Attending Physician: The law requires that the death certificate be executed ours after death.

neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the bunal-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performe 26. Place of Death (Check onl. one) Be 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Naturai Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar EASTERN AVENUE, BAUTIMORE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ANICE LEUNG

NOV 0

7 2007

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

Saltimore, Maryland 21215-0036

The law requires that the death certificate be executed To the Hospital or Attending Physician; nours after death.

neral Director; After this ce
filled in by the funeral direc within 24 hours a

To the Funeral C

completely filled

> State Registrar

(Check only

29h. Signature and title of certifier

MD

29c. License number RES 000

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) November 06, 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 SOUTH HANOVER STREET, BALTIMORE, MD 21225 31. Date filed (Morfth, Day, Year)



State Registrar

31. Date filed (Month, Day, Year) NOV 0 7 2007

Name and address of perion who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Michael J. LaPenta, M.D., 445 Defense Highway, Annapolis, MD 21401

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Olecski November 03-05 AM 1,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harbor Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year, Aug 23, 19 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 €M 2 □ F Months Days Hours 219-10-5415 81 Maryland Director 1926 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatilh and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or Items be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √Yes 2 No Md. Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? St. Victor Street 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 fes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Clerk U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P John F. 01ecski Sr. Julia Zebron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Olecski 3827 St. Victor Street Baltimore, Md. 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/5/07 Baltimore, Md. 22. Name and Address of Facility $\mbox{Gonce Funeral Service $P.A.}$ 21. Signature of Funeral Service Licensee 4001 Ritchie Hgwy. Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Urosepsis one day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive heart failure Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of: Examiner the burial-transit Prostate cancer and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? certific te has been signed by the atterector, age 2 should be detached for Month 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ûnknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1□ Yes No death? 1 ☐ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို Inpatient 3□ DOA 2 ☐ ER/Outpatient After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending after death.

I Director: Al investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD November 1,2007 00 i 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle Kim 3001 s. Hanover st. Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		1 _ State		artment of Health rtificate of Deat			iene _{eg. No} 2 ()	0.7	35752	
-		Registrar 1. Decedent's Name (First, Middle, Last)	eg. NoZ U	0 1	3. Time of Death					
hysicia /Medic		Linda A	s	Month Novemb	nber 3, 2007 6:39 P M					
xamin	er	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medica.		4b. City, Town, or Location of Death Baltimore City N/A						
neral			yrs. last birthday)	If Under 1 Year If Und	er 24 Hrs.	8 Date of Birth		9. Birthpl	N/A lace (State or Foreign	
ector		212-46-8604 1 M 2 XF 60	Yrs.	Months Days Hours	s Min.	July 23	3,1947	Coun. Mar	yland	
*		Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Lo	cation				11	0d. Inside City Limits	
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important, intentions to instruct other train institutal, or nems soa or sea-i snow any Injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u>	Director	Maryland Baltimore 10e. Street and Number		10f. Zip Code	anu_	1	0g. Citizen of	What Coun	try?	
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ler m	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hispanic (If Yes, specify Cuban, Mexic	Origin? (Specan, Puerto	cify Yes or No- Rican, etc.)		ce - America ck, White, e		
xamlr	by F	1 □ Never Married 2 Married 1 □ Yes 2 및 No 1 □ Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:		1 ☐ Yes 2 ☑ No Speci	ify:		Specif			
cal E		15. Decedent's Education		dent's Usual Occupation		T	16b. Kind of B		hite Justry	
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ever	Be	17. Father's Name (First, Middle, Last)				(First, Middle, I		ne)		
matic	ို	Joseph H. Davis 19a. Informant's Name/Relationship (Type. Print) Husbar	nd 19b. Mailin	ng Address (Street and Nun		ine M. S		State Zin	Code)	
ir tran		Mr. Albert J. Peters, III	-	7th Street					•	
T of		20a. Method of Disposition 2 ☐ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Ob. Place of Dispo	sition (Name of matory or other place)		ate	20c. Location	- City or To	wn, State	
o du		4 □ Donation 5 □ Other (Specify)	Oak Lawr	Cemetery	11/	6/2007	Balti	more,	Maryland	
once.		21. Signature of Funeral Service Licensee	[Name and Address of Fac Ouda-Ruck Fun	eral 1					
10		23a. r.f.1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between								
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al er		resulting in death) Due to (or as a col			Salata Sa					
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٦	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					1/2			
	Exa	resulting in death) Last Due to (or as a cod	nsequence of):							
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ì	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Vec 2 No. 4 Pregnant at time	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year						
	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	ordeath 5	Other (specify)						
	by Ph	Part II. Other significant conditions contributing to death but no	t resulting in the ur	nderlying cause given in Par	rt I.	23e. Did tot	pacco use con	tribute to th	e cause of death?	
									ably 4 Onknown	
	Completed	Hussenholes		24a. Was an autopsy prior to com						
	So.	<i>O</i> 1			performed death? 1 Yes 2 No 1 Yes 2 No					
- 1	Be	25. Was case referred to medical examiner?		Other		(Check only on				
- 1	<u>د</u>	1 ☐ Yes 2 ☐ Mo Prospital: 1 ☐ Inpatient 27. Manney of Death 28a. Date of Injury	2 ER/Outpatien	T SELDON 4EII		ne 5 Reside			<i>ı</i>)	
	tion	1	ar) Injury	28c. Injury at Work? M 1 ☐ Yes 2[,, 0000.			
	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury building, etc. (S)	At home, farm, stre	eet, factory, office	2	8f. Location (St City or Town		ber or Rura	l Route Number,	
-	Sel									
	edical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	y knowledge, death mination and/or inv	n occurred at the time, date vestigation, in my opinion, d	and place, a death occurr	and due to the cand at the time, d	ause(s) and m ate and place,	anner as st and due to	ated. the cause(s)	
	Me	29b. Signature and title of certifier		29c. License numbe	er —	2	9d. Date signe	d (Month, i	Day, Year)	
		Ronald ATTANT	7310	D-280	997		11/5	707		
		30. Name and address of person who completed cause of death		Print)	مسعراء	7 1	1	1 -		
Stat		31. Date filed (Month, Day, Year) 32. Biggistrar's 8	Signature .	Sute 10	08,	BNJ	MO	1.6	123/	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Amend #8, perFh, 0873, 11/13/07 TT Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** 1/15 2007 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ral Tim 8. Date of Birth 6/23/1934 9. Birth place (State or Foreign (Month, Day, Vear) 5. Social Security Number If Unde st birthday. **Funeral** Months Days Hours Min 1 □ M 2 F Yrs. 224-40-8352 Director Va Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov Examiner must be notifled at Md. NA Baltimore 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 2404 N. Calvert Street Apt. 1 21218 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hyglene.
Int: If Item 27 Is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled NA 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Peace Irbbie Johnson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trau once. Yvonne Rice Daughter 3224 Chesterfield Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-8-07 Trinity Cem. Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Onewate disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy page performed certificate 2 □ No or Attending Physician: director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 patient ို 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Dalatural 2 Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my crimina due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Sigrature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) s of person who completed 301 St. Paul Pi 31. Date filed (Month, Day, 32. Registrar's Signature Year State

DHMH 17 Rev 1/2001

Registrar

Registrar

29b. Signature at

31. Date filed (Month, Day, Year)

title of cert

NOV 0

30. Name and address of person who conveted cause of death (Item 23a) (Type, Print)

Susan J. Miller, MD 6844 Tulip Hill Terrace, Bethesda, MD 20816

32. Registrar's Signature

ASS C. Sixon

29c. License number

D35579

29d. Date signed (Month, Day, Year)

State

Registrar

Baltimore, Maryland 21215-0036

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32. Registrar's Signature

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2007

31. Date filed (Month, Day, Year)

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		for State Registrar Amend #17, per		•		tificate of		, ,	eg. N2 0 0 7	35756
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Examin		4a. Facility Name (If not institution, gir	re street and number)	Ation	me	4b. City, Town, o	Y DVD ()	tv	4c. County of De	ath
Funeral Director		099-26-2758	Sex 7. Age	(In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8 Date of Birtl (Month, Day 09/27/1	(Year) (irthplace (State or Foreign Country) CCHOSLOVAKIA
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or 28a be not!!	Funeral Director	10e. Street and Number		DROOM	<u> </u>	10f. Zip Code			10g. Citizen of What	
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s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. If Health and Mental Hygiene. Other traumatic event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:)		Yes, specify Cub	Hispanic Origin? (S ean, Mexican, Puert Specify:	o Rićan, etc.)	Black, Wi	wHITE
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id 2 sh Ith and 17 is m traum		19a, Informant's Name/Relationship							er, City or Town, State	
of Hea		ROSALIA PASCHKUS 20a. Method of Disposition	•	20b. Place ceme	of Dispos	sition (Name of natory or other pla	ace)	ROOKLYN Date	NY. 11210 20c. Location - City	or Town, State
Page tment tant: II		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	ify) 11	BETH					VOODBRIDGE	
permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any Injury or other trai once.		21. Sign Aut of uneral Service Lice	Mug	er	- 1	Name and Addr			NSON & BRO	DS INC. _E. MD 21208
Physician /Medical Examiner	Ť.	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. ON A. Due to (or asia	COTIV	le of): I ar	er the mode of dy 1.Cart -Luy	Failur of ISEA	l	rest,	Approximate Interval Between Onset and Death Open In Provided Than by The Years
ficate be executed ficate be executed by sician and strensit street burial-transit	edical Examiner	day, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Cara Due to (or as a	iom	401	pathy				greater than 1;
The law requires that the death certificate are has been signed by the attending physicage 2 should be detached for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal dea		Ectopic pregnand Other <i>(specify)</i>	су		23d. Date of Month	delivery Day Year
quires that	ρ	Part II, Other significant conditions	contributing to death but	t not resulting	g in the ur	nderlying cause gi	iven in Part I.	23e. Did t		e to the cause of death? Probably 4 □Unknown
The law requir cate has been si	Completed							24a. Was auto perfo 1∐ Yes	an 24b. Were prior death 2 No 1 \(\)	
yslclan: Th	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatier	nt 2 🗆 ER/	Outpatien	t 3 DOA OI	ther	ath <i>Check onl</i> of	one dence 6 □Other (S	Specify)
othe Hospital or Attending Physician: within 24 hours after death of the Funeral Director; After this certifical completely filled in by the funeral director,		27. Mann of Death Natural 5 Pending Accident investigati	28a. Date of Injury	y 28	b. Time of Injury	28c. Inja		,	how injury occurred	poony
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3☐ Suicide 6 ☐ Could not determine	be d 28e. Place of inju- building, etc	ry - At home, . (Specify)	, farm, stro	eet, factory, office	9	28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
Hospit 24 hours Funera tely fille	edical (Physician: To the best o aminer: On the basis of and manner stat	examination						
To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner sta			29c. Licer	nse number		29d. Date signed (M	onth, Day, Year)
,		1 Colon Ja	1 m	D		19	516		wovemb	Ler 6,2007
t		30. Name and address of per wh	o completed cause of de	eath (Item 23	a) (Type,	Print)	Sina	1 Hosp	ital of	Baltimore
Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	15°	Corre				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Everett G. Partridge 5:30 a. /Medical November 1, 2007 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2000 Monkton Rd. Monkton Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday)
77 Yrs. 8. Date of Birth (Month, Day, Year) July 6, 1930 **Funeral** 9. Birthplace (State or Foreign 1 □**X**M 2 □ F Hours Days 202-24-9006 Yrs. Director Michigan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at Maryland Baltimore Director Monkton 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 2000 Monkton Rd. 21111 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes Give 19
Year or Dates: 19 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo þ Specify. 3 ☐ Widowed 4 ☐ Divorced Specify. White 1954 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry And Mental Hygiene.
7.27 Is marked other than "r traumatic event". Elementary/Secondary (0-12) College_(1-4or 5+) Development Industrial Developer permit. Pages 1 and 2 should be filet.
Department of Health and Mental Hygi.
Important: If Item 27 is marked any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **Everett Percy Partirdge** Jane Harris Hazzard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 Monkton Rd. Monkton, Maryland 21111 Mrs. Mary V. Partridge Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 11/02/07 Sykesville, Maryland All County Cremation Services, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician malogenous disease or condition resulting in death) UWS /Medical Due to (or as a consequate of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (of as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. the attending physician the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has was an autopsy performed?
Yes 2 No 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 Inpatient After this 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day 1 Natural 2 ☐ Accident 1 Tes 2 🗆 No within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NW 2, 2007 30. Name and address of person who combined cause of death (Item 23a) (Type, Print)

Judith E KARP Johns Hopkins Sidney Kimmel Cancer Cty Baltimore 10.

21. Data filed (Marth Day York)

22. Registrar's Signature 10 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 0 Registrar

DHMH 17 Rev 1/2001

State Registrar

NOV 0 7 2007

Tasha Greenberg MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

OCME

steer 18 Ash

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2007 Yeer **Physician** 7:15 A M 27 CCT Charlotte Marie Ruth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8542 Kavanagh Road Dundalk Baltimore Co. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2CXF Director 215-40-6133 March 8,1942 West Virginia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Dundalk Baltimore Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code ō Items 23a United States 21222 8542 Kavanagh Road Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Iter 1 ☐ Yes 2 🛛 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Floral Designer Florist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Layfield Howard Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Thomas J. Ruth/Husband 8542 Kavanagh Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State ö Department of Important: If any injury or one * 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 10/31/2007 Towson, Maryland 21. Sign vure prineral Service Lionsee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 k 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final obstructure Pulmonory Piscore Physician Chonic 4 ERTS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Y as 2 No 3 Probably 4 Unknown of Vital Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 1 autopsy 2 No 1 Yes 2 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Division o the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 T Homicide within 24 hours a
To the Funeral C 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2007 04575 29 marther noul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beltz mare. Matthew McNkbacy 4940 26 storn 21224 32 signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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2007

		1 - For State Registrar	State of Marylar		artment of H rtificate of L		viental Hy	giene Reg. Na 0	07	35760
	Ш	1. Decedent's Name (First, Middle, Last)				2. Date of De Month		Year	3. Time of Death
Physic Med		Joseph A.	Rose				NOV	1	2007	11. 15 PM
Exam	iner	4a. Facility Name (If not institution, give			4b. City, Town, or		1	4c. Count	y of Death	
· · · · · · · · · · · · · · · · · · ·		GOOD SAMARITAN 5. Social Security Number 6. Se		last birthday)	If Under 1 Year	IMORE If Under 24 Hrs.	8 Date of Bir	th	9. Birth	place (State or Foreign
Funera Director	1		M 2□F 67		Months Days	Hours Min.	8. Date of Bir (Month, Da Jan . 1	7, 1940	Mar	place (State or Foreign intry) yland
pui »		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Lo	cation			-		10d. Inside City Limits
Maryla f shor	ō			Esse						1 □Yes 2 No
r 28a-	irect	10e. Street and Number			10f. Zip Code			10g. Citizen of		ntry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	3 Old Maple Co	ourt		2	1221		US	A	
er dea tems	nne	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puert	pecify Yes or No o Rican, etc.))- 14. Ra Bla	ce - Ameri ack, White	can Indian, , etc.
Irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1		1 □ Yes 2√x No	Specify: White				
72 hou 72 hou nature		15. Decedent's Edu (Specify only highest grad	leation	16a. Dece	dent's Usual Occupa	ation	kina	16b. Kind of E		•
ithin in han "han "hed	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	kind of work done of DO NOT use retired		ning .			na Care
Hygiel		17. Father's Name (First, Middle, Last)	4yrs	ļ P	hysicis	t 18. Mother's Nan	ne (First, Middle		ente	<u>:</u>
nd 2 should be filed within all all as should be filed within alth and Mental Hygiene. 27 is marked other than ar traumatic event, the Me	To Be	John Rose					esa Wi		,	
and M and M s mar	-	19a. Informant's Name/Relationship (T)	/pe. Print)		ng Address (Street a					' '
T and 2 Health tem 27 i		Patricia Rose	·		OLd Ma	ple Cou				
permit. Pages 1 Department of H Important: If iter any injury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	Removal from State Ho	Place of Dispo cemetery, crei DILY H	esition (Name of matory or other plac III Cem	etery 1	Date 1/6/07	20c. Location Balti	-	
ermit. epartn epartn ny inju		21. Signature of Funeral Service Licens	see D	22	2. Name and Addres	ss of Facility 3	00 Mac	e Ave.	Ba]	Lto. MD
		23a. Part1. Enter the disease, or comp	en	The Downston	Connell				ssex	21221 Approximate
	a.	shock, or heart failure. List only o	ne cause on each line.	tii. Do not em	er the mode or dym	y, sucii as calulat	or respiratory a	mest,		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. SEPSIS Due to (or as a consec	quence of):						
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icate be executed physician and sthe burial-transit			ď	. ,						
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death certific	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet	aldeath 3	∃Ectopic pregnancy	,			ate of deliv	very Day Year
he dei the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify)					
that the hed by		Part II. Other significant conditions co	entributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
quires en sigr uld be	ed by	CHRONIC OBSTRUC	TIVE PULMONA	FY DI	SEASE,		1 🗆	Yes 2 □ No	3∏ Pro	obably 4 Unknown
law reas bee	plete	ISCHEMIC COLI	TIS, PERIPHERA	IL VAS	CULAR D	ISEASE	24a. Was	an 24b	. Were aut	topsy findings available ompletion of cause of
or Attending Physician: The after death. Director: After this certificate he in by the funeral director, page	Completed		,				perfe 1∐ Yes	ormed? 2X No	death? 1 ☐ Yes	2 X No
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To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		rsician: To the best of my kn finer: On the basis of examin and manner stated.		vestigation, in my o	pinion, death occi				
To t To t	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon								
		Marke	M.D.	00.) 77		- 000		NOV	2 nd	2007
10		30. Name and address of person who c ZUBAIR SHAIKH, GOOD	SAMARITAN HO	SPITAL,		FAVEN	BLVD, B	ALTIMO	PE, I	ND -21239
S Regis	tate trar	31. Date filed (Month, Day, Year)	32 Registrar's Sign	K A	and I					
		NOV 0 7 20	UI Jasans	- Park						

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ROSE,

07-08485 Alan Reinke Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 35761

		For State		Certi	ficate of	Death				Reg. No.		10 = 10 = 1	
Physiciar edical Examin	/ 1 er	Decedent's Name (First, Middle Alan Robert	Reinke						2. Date of De Month Novembe	Day er 1, 2007	Year	3. Time of Death 1015 hrs	
	4	a. Facility Name (if not institution 18216 Colonel Henry		per)	4	b. City, Town, Hagersto		n of Death		Washington			
Funeral Director	- 1	Social Security Number 393–78–7339	6. Sex 7.	Age (In yrs. las		If Under 1 \ Months [ear If Un ays Ho	urs Min.		5/1960	YYY) 9. B Fore C	irthplace (State or ign ounty)	
and f show any once.	1		agamie		own or Locati		Δ			10q. Citizen o	f What Co	10d. Inside City Limits 1 Yes 2 X No untry?	
with the Maryland ans 23a or 28a-f sho be notified at once.	اق	Oe. Street and Number W10895 Cty Road	d WW				961			United States			
death r ite	Funeral	11. Marital Status 1 Never Married 2 X M	12. Was Deced	2 X No	1	s Decedent of es, specify Co	iban, Mexic	can, Puerto	Rican, etc.)	Spec	white, etc. cify: Wh		
15-0036 filed within 72 hours after I Hygiene. do other than "natural", o	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12) 10		ify only highest grade completed) College (1-4 or 5+)		it's Usual Occord ost of working	life. DO N	OT use reti	vork done red)	16b. Kind o	of Busines		
P a y a 되	ا ا	17. Father's Name (First, Middle					18.Mo	ther's Name		e, Maiden Surr	_		
12. Id be Menta narke	To Be	Robert Reinke			19b. Mailin	g Address (S	Street and	Sladys Number or F	Rural Route N	neidewe Number, City or	nd Town, St	ate, Zip Code)	
and sho	-	Brenda Reinke, Wife W10895 Cty Rd. WW, New London,								don, WI	, WI 54961 Dc. Location - City or Town, State		
		20a. Method of Disposition 1 X Burial 2 Crematic 4 Donation, 5 Other 5	Specify:	m State Pa	rematory or other place) ark Cemetery 11/07/20					2007 Ogdensburg, WI ne and Hanson Funeral Home			
Baltimord permit. Pages 1 Department of 1 Important: If injury or other	-	21. Signatur Funeral Servic	e Licensee	MOTITIE	1 20	9 W. C	ook s	Street	, New	London	, WI		
Physician 'Medical aminer		23a. Part I. Enter the disease, of failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	se on each line. se a. Atheroso	lerotic (cardiova				or respiratory	arrest, shock,	or heart	Approximate Interva Between Onset and Death	
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Box 68760, c death certificate be executed the attending physician and ed for use as the burial - transi	Physician//	23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 L	4 Pregn	ant at time of de	- 11	etal death Other (Specif)		ctopic pregr		-	onth	Day Year	
e = e	þ	Part II. Other significant cond	- Land		resulting in the	underlying a	iuse given	in Part I.				e to the cause of death? Probably 4 Unknown	
Division of Vital Records, P.O. Box 68: tal or Attending Physician: The law requires that the death certifins the death certifinal birector: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	Completed								-	a. Was an autopsy performed? Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No			
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n of Vit ling Physic After this of funeral dire	7	1 V Yes 2 No 27. Manner of Death	28a. Date (Month	of Injury n, Day,Year)	ER/Outpatie	f Injury 28	c. Injury at	Work?		ribe how injury		Julian Cooke	
Division of Vital Division of Vital With Early and To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Certification:	2 Accident In 3 Suicide 6 C	28e. Place of Injury - At home, farm, street, factory, office building, etc.									or Rural Route Number, Cit	
Co the Hospita within 24 hours To the Funera	Medical Ce	4 Homicide	Physician: To the beaxaminer:On the basis	st of my knowle of examination	dge, death occ and/or investi	curred at the t	me, date a	ind place, a ath occurre	nd due to the	cause(s) and date and place	manner as e, and due	s stated. to the cause(s)	
To with Com	Mec	29b. Signature and title of cer	and manners	dateu.	<i>y</i> ~	29c.	License nu	ımber		29d. Da		(Month, Day, Year)	
D		30. Name and address of personal Tabiullah Ali M.D.	son who completed cau Assistant Medic			enn Street	Baltimo	ore, MD 2	21201				
_s	tate	Zabiullah Ali, M.D. 31. Date filed (Month, Day, Ye		egistrar's Signa			= = = = = = = = = = = = = = = = = =						
Regis		11011	7 2007	1. 185 A	15 Am	Mark P				OC.			

Physicia /Medic Examin	ä
	Į
Funeral	
Director	

death with the Maryland 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

sician and bunal-tran Division or Vital Records, P.O. Box 68760, led by the attending physician detached for use as the buna To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral

For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Bernard L. Shipp 11:30 P M 31, 2007 October 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore City N/A 6923 Eastbrook Ave. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Months Days 1 M 2 □ F Yrs 234-44-2697 Oct. 19, 193d West Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1XXYes 2 □ No Baltimore City Director N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6923 Eastbrook Ave. 21224 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced 1948-50 White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Kraft Foods Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rufus Russell Shipp Etta King 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21224 6923 Eastbrook Ave. (Wife) Mrs. Ruth A. Shipp 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State 5 ☐ Other (Specify) Garrison Forest V.A. Cem. 11/5/2007 Owings Mills, MD 4 □ Donation 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the elsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 21 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No ၉ 2 ER/Outpatient 3□ DOA 27. Manner of Seath 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Płace of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed of BIVD SURE 708 BA/+0. Mb 21224 DIAA MIKHAI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2007 NOV 0

State Registrar Holy Cross Hospital Silver Spring, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dr. Rama Kapoor
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien [] [] 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 220 a **Physician** Staples November 700G Hitchugh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville Rockville Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 7/13/1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** 1 XM 2 □ F Virginia 89 223-07-7451 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County in than "natural", or Items 23s or 28s-f show the Medical Exeminar must be notified at 1 ☐ Yes 2 No Rockville MD Montgomery Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 20850 303 Adclare Road permit. Pages 1 and 2 should be filed within 72 hours atler death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, Itle May cal Examinat must once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 □XYes 2 □ No
If Yes, Give
Year or Dates: WWII Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: White 3€XWidowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Advertising/Banking Elementary/Secondary (0-12) College (1-4or 5+) Advertising Executive 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Fitzhugh Pierce Dennison Dudley Staples 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9806 Mahogany Run, Ijamsville, MD 21754 Fitzhugh D. Staples, Jr./son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ///6/07 Beltsville, MD Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signeture of Funeral Se M00382 Stole & Lolyman 933 Gist Ave Silver Spring, MD 20910 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Vascular Dementic y-ears **Physician** /Medical Due to (or as a consequence of): Examiner erebias Vascular Dissous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Hypothyroidism Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 4, 2007 **B**4 | 794 who completed cause of death (Item 23a) (Type, Print) 911 Russell Avenue Gaitters burg, MO 20879 Priscriba Callahan-tyon, mo 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State	Certificate of Death Reg. No.										
Physiciar		egistrar . Decedent's Name (First, Midd	le,Last)			2	. Date of De Month	Day	Year		Time of Death 2225 hrs		
edical Examin	er	Ralph		ward	5	Simmon	t,IV		October :	29 <u>,</u> 20			22231115
7	4	a. Facility Name (if not institution	n, give street and nu	ımber)		4b. City, Town,		of Death		40	c. County of	Death	
		Sinai Hospital				Baltimore							(O)
Funeral	5	. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Y			8. Date of E	sirth(MM	/DD/YYYY)	Foreign	ace (State or
Director		60 74 3000	1 XM 2 F	16	Yrs		ays Hours	S Min.	03	21	92	Countr	y) PA
		62-74-1099 Usual Residence of Decedent											
any		I0a. State 10b. County		10c. City,	Town or Locat	tion							d. Inside City Limits
*		MD B	altimore		Ρi	ikesvi	lle					1	Yes 2 X No
ylane a-f sł	흱⊢	10e. Street and Number	arcrimore.			10f. Zip Cod				10g. Cit	tizen of Wha	at Country	?
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										Indian, Black,			
th wi			Married Armed F	orces?	lf \	Yes, specify Cu	ban, Mexicar	n, Puerto F	Rican, etc.)		White	, etc.	
or dez	ᇍ		1 Yes	2 X No	1	Yes 2x	No specify	<i>/</i> :			Specify:	Bira	acial
s afte	≥⊦	15. Decedent's Education (Sp	Lor Dates:		16a. Decede	nt's Usual Occ	upation (Give	e kind of w	ork done	16b.	Kind of Bus	siness/Indu	ıstry
hour "nate	eted	Elementary/Secondary (0-12		1-4 or 5+)	during n	nost of working	life. DO NO	T use retire	ed)				
36 lin 72 than dical	읪	10th grade	na		St	udent					Sch	1001	
5-0036 led within 7 Hygiene. I other than	Comple	17. Father's Name (First, Middle	e, Last)				18.Mothe	er's Name	(First, Middle	, Maide	n Surname)	r	
215. be filed ntal Hy rked of	B B	Ralph E. Si		т			And	rela	Watk	ins			Option to I
212 uld be Ment mark c ever	0	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address (S	Street and Nu	ımber or R	ural Route N	lumber,	City or Town	n, State, Z	ip Code) 2120 B
MD ;		Angela Watk		er	7921	Scott	s Lev	7el F	Road,				
and 2 lealth tem 7	ŀ	20a. Method of Disposition			Place of Dispo	osition (Name o	f cemetery,		Date	200	. Location -	City or To	wn, State
more Pages 1 nent of H ant: If i		1 X Burial 2 Crematic	on 3 Removal	from State LO	crematory or c cust	United		1	10 107		. 1		וה או
tim Ement	1	4 Donation 5 Other		Me	thodis	United St Chu Name and Add March	rch Iress of Facil	I I I I	/6/07	10	OTUM)1a,	INC _
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	1	21. Signature of Funeral Service	e Licensey	L	1 - 1	March	F/H W	Vest	. D.	1 - 4	m 0 16 0	Ma	21215
	1	23a Part I. Enter the disease,	or complications that	caused the death	Do not enter	4300 W	ing, such as	cardiac or	r respiratory	arrest, s	hock, or he	art	Approximate Interval
Physician /		failure. List only one caus	e on each line.										Between Onset and Death
aminer	11	In mediate Cause (Final diseaser condition resulting in death)		Nound of Abo									
1	4	an condition resulting in dodary	Due to (or as	a consequence o	J1 / .								
	ᡖ	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of	of):								
	딑	(Disease or injury that initiated	C.										
ي. √ي. اچ. √ي	Examiner	events resulting in death) Las		a consequence	ot):							1	
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'60, cate be execute physician and he burial - tra	Medical	UNPENDED	X AMENDE	rME 08/5.	1/11/08	TT		_		-	23d, Date o	f delivery	
Box 68760 e death certificate b the attending physical for use as the bu	~	IF FEMALE: 23b. Was decedent pregnant in	tho	s, outcome of pre		Fetal death	3 Ecto	opic pregna	ancv	- 1	Month	Da	y Year
ox 687 eath certific attending for use as t	Physician	past 12 months?		e birth gnant at time of d		Other (Specify		- FI - S	,				
OX leath	Š	1 Yes 2 No 9	Jnknown 9 Uni	known		0 11 10 1 1 - 1 2 2							
that the dined by the detached	F.	Part II. Other significant con-	ditions contributing	to death but not	resulting in the	e underlying ca	use given in	Part I.					ne cause of death?
P,O es that the igned by be detac	ξ								1	Yes 2	№ No 3	Proba	bly 4 Unknown
ords, P w requires t us been sign should be	Completed					<u> </u>			24a. W		24b.	Were auto	opsy findings available ompletion of cause of
aw re	pte								P	utopsy erfor <u>me</u>	<u>d</u> ?	death?	por mantrag
Rec The I cate I page	Ö	_								es 2	No	1 🗸 Yes	2 No
tal Recician: The	Be	25. Was case referred to med examiner?					Place of Dea				.i.d	Other:	
Vit this c	To E	1 ✓ Yes 2 No		Inpatient 2	ER/Outpatie		<u>, </u>		ng Home 5		idence 6		
Division of Vital Records, tat or Attending Physician: The law requir its after death. al Director: After this certificate has been so led in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Ë	27. Manner of Death	28a. Da	ate of Injury onth, Day Year) 9, 2007	28b. Time of 1754 hrs		. Injury at W		Subject s	shot by	y police	160	
on tendi	atio.		enuing				Yes 2						- L Day to Manakar City
ViSI or At fter d	ijij		ould not be 28e. P	lace of Injury - At	home, farm, s	treet, factory, o	ffice building	, etc.	or Toy	on State	۱د		al Route Number, City
Division spital or Attendi nours after death. neral Director:	Certification:	4 V Homicide		ify) Local Stre						_	oad, Balti		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier 1 Certifying	Physician: To the	best of my knowle	edge, death oc	curred at the ti	me, date and	place, and	d due to the	cause(s) and mann	ar as state due to the	d. e cause(s)
To the Hos within 24 h completely	Medical		xaminer: On the bas and mann	sis of examination er stated.	and/or investi				at the tille,				
F 3 F S	Ž	29b. Signature and title of cer	tifier				icense numb	per					nth, Day,Year)
		May B	and 11	ND		(D.C.M.E.			[October 3	10, 2007	
t.		30. Name and address of per	son who completed of	cause of death (Ite	em 23a)								
C/		Melissa Brassell, M	D Assistant I	Medical Exam	niner 11	1 Penn Stre	et, Baltim	ore, MD	21201				
S	tate	31. Date filed (Month, Day, Ye	^{9r)} 2007	Registrar's Sign	eture	des							
Regis		I TO A C	LUUI Men	State of	ASS ASS	Jan Barrell							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35767 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Shirley Elizabeth Spencer 2007 3:35a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Future Care-Canton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 🖫 F 70 213-32-0224 1-23-1937 Md. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County Director 1 Yes 2 No Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 537 N. Kenwood Avenue 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼ No Specify Black Completed by 3 ☐ Widowed 4 € Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) mentary/Secondary (0-12) College (1-4or 5+) Laundry Seton Institute 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James McNair Carter ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 537 N. Kenwood Ave., Baltimore, Md. Shirlena Spencer Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cem. 11-6-07 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 4 1101 E. North Ave., Baltimore, Md 21202 anner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Attheoscleroto Due to (or as a consequence of): Sequentially list conditions, if any, leading to infine orate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown

Physician /Medical Examiner

Department o Important: If any Injury or

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

requires that the death certificate be executed

physiclan

the

certificate

this

After

within 24 hours a

Physician:

or Attending

burial-tran the as 1 use a ф detached s been signed by the should be detach Completed by page 2 To Be Certification: ours after death.

nerat Director: A
filled in by the fu

Division or Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

23e. Did tobacco use contribute to the cause of death?										
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown										
24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No										

25. Was case referred to medical Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient

	26. Place of Death (Check only one)										
Outpatient	3 🗆 D	OA	Other: 4 Vursing H	lome	5 Residence	6 ☐Other (Specify)					
b. Time of Injury		28c.	Injury at Work?	28d.	Describe how inju	ury occurred					

27.	Manner of Death		ï
	1 Natural	5 Pending investigation	
	2 Accident	investigation	
	3☐ Suicide	6 ☐ Could not be	1
	4 ☐ Homicide	determined	1

28a. Date of Injury (Month, Day Year) 28

2 □ ER

28a.	Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?	
			М	1 ☐ Yes 2	□No
28e.	Place of injury - At he building, etc. (Special	ome, farm, stree	t, fact	ory, office	

)	,
	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 00053337 29d. Date signed (Month, Day, Year) 11/6/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Md 21209 Suite 203

State Registrar

31. Date filed (Month, Day, Year) NOV



DBMB 17 Bev 1/2001

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



29d. Date signed (Month, Day, Year)

OCTOBER 30, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 _ For State	State	of Maryla		artment of rtificate of				giene Reg. No 2	007	35769	
		Registrar 1. Decedent's Name (First, Middle	e, Last)			imouto or	Dout		2. Date of Dea	rieg. Notes			
Physic		Mark <	Sm	,th					Month 1 (Pay	2007	4:10 P M	
/Medi Examir		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town,	or Location	of Death	11	4c. C	County of Death		
Xuiiii		14422 Seneca Ro	oad			Germant	own			Mon	ntgomer	V	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days			8. Date of Birth (Month, Day	h	9. Birth	place (State or Foreign intry)	
Director		220-70-6161	1 X M 2□F		52 Yrs.	World 5 Bays	Hours		Jun 11,			sylvania	
and *		Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Lo	cation						10d. Inside City Limits	
farylarylarylarylarylarylarylarylarylaryl	ò	,			•							1 □Yes 2/□XNo	
the N 28a-i	rect	MD Montgo	omery	Ger	mantown	10f. Zip Code				10a. Citize	en of What Cou	ntrv?	
with 3a or 1 be	ā	14422 Seneca Ro	and			20874				USA			
ms 2:	Funeral Director	11. Marital Status	12. Was De	cedent Ever in	U.S. 13.	Was Decedent of	Hispanic O	rigin? (Spec	cify Yes or No-		4. Race - Ameri		
after or liter		1 ☐ Never Married 2 🂢 Marı	ied Armed I	2 X No		If Yes, specify Cu			Rican, etc.)		Black, White	, etc.	
ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates:		1⊡Yes 2∏XNo	Specify		٤	Specify: Whi	te		
72 h "natu	Completed	15. Deceden (Specify only highe	t's Education st grade completed	1)	(Give	dent's Usual Occu kind of work done	durina mo	st of workin	g	16b. Kind	d of Business/Ir	ndustry	
within she.	ם	Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT use retir	/						
Hygied Int. ther		17. Father's Name (First, Middle,	Last)		Mortga	ige Broke		ner's Name	(First, Middle.		gage Co: Surname)	mpany	
d be ental ced o	o Be	Robert Charles	-			Rendena Andrist							
shoul nd Mo marl	ျို	19a. Informant's Name/Relations			19b. Mailir	ng Address (Stree				er, City or	Town, State, Zi	p Code)	
nd 2 alth a 27 is		Theresa M. Smit	h/wife		1	Seneca							
item other	ll i	20a. Method of Disposition			Place of Dispo	sition (Name of natory or other pl	ace)	Da	ate	20c. Loca	ation - City or T	own, State	
mit. Pages partment of portant; if it portant; if it it y injury or o		1 ☐ Burial 2 反 Cremation 4 ☐ Donation 5 ☐ Other (S		n State Ch		ce Cremat	· .	11/06	5/07	Belts	sville,	MD	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	01	22	Name and Add	ess of Faci	ility		00 I	P O Por	v 78/	
D 88 E 8 8		dever!	KHR	COMO	1251 Be	verly I	Hock	rotte	PA	Clar		MD 21029	
		23a. Part1. Enter the disease, or shock, or heart failule. List	complications that only one cause on	caused the dea each line.	ath. Do not ent	er the mode of dy	ring, such a	s cardiac or	respiratory ar	rest,	. 100 (113	Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	, Kidn	ey Canc	er							Onset and Death	
/Medical Examiner		resulting in death)	Due to	o (or as a conse	equence of):								
3	<u>_</u>	Sequentially list conditions,	b. Due to	o (or as a conse	equence of):								
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	\$	0 (01 00 0 001100	4401100 01).						- 1		
execu and al-tra	xar	that initiated events resulting in death) Last	cDue to	o (or as a conse	equence of):							-	
The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	dical		d										
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leath certific attending p	hysician/M	IF FEMALE: 23c. If yes, outcome pf pregnancy 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy									23d. Date of delivery		
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has be 2 s	Completed								24a. Was a autop	sy	prior to co	opsy findings available ompletion of cause of	
The cate cate pag	ပိ									rmed? 2 No	death? 1 ☐ Yes	2□No	
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To the Hospital or Attending Physician: within 24 hours aler deafh. To the Funeral Director Affer this certifics completely filled — by the funeral director,	Medical	one) 2 Medical	Examiner: On the and me	nner stated.	adon and/of in			eath occurre	u at the time,	uate and p	piace, and due	to trie cause(s)	
To 1 With To t	Σ	29b. Signature and title of certifie	1.1.1/1	2			se number				signed (Month	**	
A		prenone	molle		u)	D6461	.5		1	Novem	iber 5,	2007	
20		30. Name and address of person	who completed ca	i		·							
~		Genevieve Wrobl 31. Date filed (Month, Day, Year)		.D. 13		ard Dr.	Rockv	/ille,	MD 208	850			
Sta Registi		NOV 0		Hagistrar's Sign		book)							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER VAOMI Schuggm

4a. Facility Name (If not institution, give streat/and number) 200⁷ AM 4:50 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea 02/02/1915 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 ₩ F 212-26-7275 92 Director SC Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ∐Yes 2**Y**∏No Director BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 CAVESWOOD LANE Funeral 21117 U.S.A. 14. Race - American Indian, Black, White, etc. WHITE 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No چ Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) SALES INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAFFE FANNYE DUBOTS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTIN SCHUGAM / SON 16 CAVESWOOD LANE - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEMORIAL 11/05/2007 REISTERSTOWN, MD SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Mel-6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 204rs Alzhumoni /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year signed by the aid be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 🔲 Yes 2 Accident completely filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tine of certifier 29d. Date signed (Month, Dav. Year) ð 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33 31. Date filed (Month-Day, Year) 32. Figuristrar's Signature

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

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W. BELVESELE AVE.

BALTINORE MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DABATUNDE

31. Date filed (Month; Day; Year)

AJANI

32. Registrar's Signature

		1 - For State Registrar	State Of Ma	,		rtificate of			Reg. No.	007	33112		
Physic	ian	1. Decedent's Name (First, Middle,	SCHUL	-)			2. Date of De Month	Day	Year	3. Time of Death		
/Medi	ical	AUDREY		. 1 4		4h Cihr Tourn	or Location of Dea	NOVEN		2 2 0 ol Dunty of Death	6:30 AM		
Exami	ner	4a. Facility Name (If not institution,				BALTIN		atri	40.00	BALTIMO	DE		
Funeral			Sex 7. Age		last birthday)	If Under 1 Year	If Under 24 Hr	S. 8. Date of Bir	th Your	9. Birthp	ace (State or Foreign		
Director		122-26-4423	1□ M 2⊠F 74	}	Yrs.	Months Days	Hours Mir	03/01/	1933	CALIF	ORNIA		
and * .		Usual Residence of Decedent 10a. State 10b. County		10c. City	r, Town or Lo	cation				10	Dd. Inside City Limits		
Maryl f sho	ğ	MD BALTI	MORF	R/	ALTIMO	RF					1 ☐ Yes 2 No		
h the	irec	10e. Street and Number	10112		(ETTIO	10f. Zip Code			10g. Citizer	n of What Coun	try?		
23a c	Funeral Director	7920 SCOTTS LE	VEL ROAD			2120)8			U.S.A.			
er dez items ner m	nue	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13.	Was Decedent of F f Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or No erto Rican, etc.))- 14.	. Race - America Black, White,			
Irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	d 1 □ Yes 2 🚺 N If Yes, Give Year or Dates:	O		1 ☐ Yes 2 🎇 No	Specify:		Specify: WHITE				
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ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. I	DO NOT use retire	d)	orking		5005			
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d be idental	To Be	UNOBTAINABLE)BTA	NABLE		UNOBTA		, maraon ou	UNOBTAINABLE			
ie, with y failed KILL COOOOO I and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. I health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	-	19a, Informant's Name/Relationship				ig Address (Street		Rural Route Numb	er, City or T	own, State, Zip	Code)		
and 2 salth a		DEBORAH RILEY /	GUARDIAN				VENUE -	TOWSON.	MD 21	204			
permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from State	20b. P	lace of Dispo	sition (Name of matery of the pla E HEBREW	^{ce)} 11/	Date 06/2007		tion - City or To			
t. Pa rtmen rtant: njury		4 Donation 5 □ Other (Spe		D/ 11				SOL LEVII					
Depariment on the control on the con		21. Signature of Funeral Service Li	insee /								MD 21208		
5 4		23a. Part1. Enter the disease, or co	omplications that caused	the death							Approximate		
Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition	a. ATH ERE		c0 57	IC & AR	DIEVAS	CILAR	0136	SASE	Interval Between Onset and Death		
/Medical		resulting in death)	Due to (or as a	consequ	uence of):	(////							
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nsit A ted	nine	Sequentially list conditions, if a y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	L. Cun to (or as a	GUIBRIU	ionice Sty:								
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that the dened by the a	Physician//	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4⊡Pregnant at t 9⊡Unknown	ime or a	eath 5L	Other (specify) _							
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hysician: The la	l E							perfo	ormed?	death? 1 ☐ Yes	•		
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ital or rs after ral Dir	Ser												
To the Hospital or Attend within 24 hours after death To the Funeral Director: ocompletely filled in by the f	Medical	29a. Certifier 1 CertifyIng (Check only one) 2 Medical Ex	Physician: To the best of caminer: On the basis of	examina	wledge, deatl tion and/or in	n occurred at the ti vestigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) ar , date and p	nd manner as st lace, and due to	tated. the cause(s)		
o the vithin (Med	29b. Signature and title of certifier	and manner stat	eu.		29c. Licens	se number		29d. Date s	signed (Month,	Day, Year)		
->-0) (Co)-	K.S.RAO	· 1	.0	0 4	3462	,	NOVE	DOEN	62007		
1		30. Name and address of person w	no completed cause of de	ath (Item	23a) (Type,	Print)	4100	h A al Al	ALLI	TOWN			

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year SOUTHERS REGINA 07:50 PM A 03 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL GOOD SAMARITAH BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) Marylard 7. Age (In yrs. last birthday) 1 M 2 9 Months 216-62-7170 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Des 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? 3712 Bonview USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 ☐ No Specify:

16a. Decedent's Usual Occupation

20b. Place of Disposition (Name of cemetery, crematory or other place)

(Give kind of work done during most of working life. DO NOT use retired)

Disabled

Benview

Cemetery 22. Name and Address of Facility 16b. Kind of Business/Industry

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

Thomas Southers

19a. Informant's Name/Relationship (Type. Print)

AKeish Forsythe-

4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licenses

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

College (1-4or 5+)

Funeral

Director

r 28a-f sh notified

ms 23a or 7

7 Is marked other than "natural", or items traumatic event, the Medical Examiner ma

and Mental Hygiene. Is marked other than

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau

death

be filed within 72 hours after

3altimore, Maryland 21215-0036

Funeral Director

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Be Completed

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that the death certificate be executed burial-trar physician the for use a the signed by t page 2 s certificate has funeral director, this After t Hospital or Attending the Funeral Director; A

Division or Vital Records, P.O. Box 68760,

07-08336 John Sturdevant P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.							
State of Maryland / Department of Health and Mental Hygiene							
Certificate of Death	200						

n Sturdeva	ant	1		ate of Maryla	nd / Depa	rtment of	Health				007 3577	
Physi	cian	E	Registrar 1. Decedent's Name (First, Middle	.Last)	Ceri	tificate of	Deam		Re 2. Date of Death	g. No.	3. Time of Death	
dical Exa		er	John Mi	chael S					Month October 27	Day Year 7, 2007	1441 hrs	
			4a. Facility Name (if not institution University Hospital	, give street and nur	nber)	4	b. City, Tow Baltimor	n, or Location of Deare	ath	4c. County o	rDeath cimore City	
Funer Directe		- 1	200 27 2070		7. Age (In yrs. la 2 2	-	If Under 1 Months		Irs. 8. Date of Birt		9. Birthplace (State or Foreign	
		L	Usual Residence of Decedent	1 XM 2 F		Yrs.			2/1//	1985	Country) M D	
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1aryland	Director	5	10e. Street and Number		10f. Zip Co		10	g. Citizen of Wh				
cath with the Maryland items 23a or 28a-f show any	notified		5495 Cedar L			21044		USA				
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The street of Health and Mental Hygiene.	Finneral		11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divo		2 X No	If Ye	es, specify C	of Hispanic Origin? (cuban, Mexican, Pue No specify:		14. Race White Specify:	-American Indian, Black, e, etc. White	
ours aft	A Par		15. Decedent's Education (Spec	16a. Decedent	's Usual Occ	cupation (Give kind of glife, DO NOT use r		16b. Kind of Bus	siness/Industry			
136 hin 72 h e. than "n	he Medical Exar		Elementary/Secondary (0-12)	College (1-	4 or 5+)		isab1	-	eliled)	Di	sabled	
21215-0036 uld be filed within 7 Mental Hygiene.			17. Father's Name (First, Middle,		me (First, Middle, M							
2121 Jld be f Mental	To Be		unkno 19a. Informant's Name/Relationsh			19b. Mailing	Address (Street and Number of	n Sturde		n State Zin Code)	
MD d 2 shot lith and n 27 is	an action		Ms. Ann Sturd		mother	5495	Ceda	r Lane #	#304 Cc	lumbia	MD 21044	
Baltimore, permit. Pages 1 and Department of Heal Important: If iten	r other tra		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Specific Specif		om State A 1	tace of Disposi rematory or oth COUR	ition (Name of ter place) 1 t y C	ofcemetery, rematory	Date 11/2/07	Sykes	City or Town, State	
Baltin permit. Departm Imports	injury o	21. Signature of Fun, ralls rivice Licenses 22. Name and Address of Facility Slack Funeral Home, 3871 Old Columbia Pike, MD 21043										
Physicia /Medic		1	23a. Part I. Enter the disease, or of failure. List only one cause of	omplications that ca	used the death.	Do not enter th	e mode of d	ying, such as cardia	c or respiratory arre	st, shock, or hea		
xamin			Immediate Cause (Final disease or condition resulting in death)	a. Multiple Inju	ries consequence of):					Death	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	or use as the bu	2	IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr	1 Live bi	ant at time of dea	2 Fet	al death ner (Specify)	3 Ectopic pre	gnancy	23d. Date of Month	delivery Day Year	
D. Bc t the dez	ached fo	≧L	Part II. Dther significant condition	9 Unkno		sulting in the u	nderlying ca	use given in Part I.	23e. Did to	bacco use contri	bute to the cause of death?	
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director:			3 Suicide 6 Could 4 Homicide	not be	of Injury - At ho Major Road		t, factory, of	fice building, etc.	or Town, S	tate)	er or Rural Route Number, City trance Road, Columbia, MD	
To the Hospital within 24 hours To the Funeral	Medical C			ysician: To the best niner:On the basis o	f examination an							
To To	Med		29b. Signature and title of certifier	and manner st	ated.		29c. Li	icense number		29d. Date signe	ed (Month, Day, Year)	
			Melina &	rasself,	MD		C	D.C.M.E.		October 28	3, 2007	
7			30. Name and address of person of Melissa Brassell, MD	who completed cause Assistant Med		·	enn Stree	et, Baltimore, M	ID 21201			
	State	e	31. Date filed (Month, Day, Year)	2007 32 Re	gistrar's Signatu	e Area	Nº J			··.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 17, 20b, c per fh 9873 11-7-07 vt

For Amend #5 Per FH 68/4 12/20/07 TT Certificate of Death

Registrar Amend #20b, perFH, g873, 11/20/07 TT Certificate of Death

Reg. No. 2 0 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 25 Barbara homas November 4, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2222 altimore Street If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day 9. Birthplace (State or Foreign Country) **Funeral** Months Hours 1 □ M 2 🕶 F Days LAND Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits artment of Health and Mental Hygiene.
ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at 1⊠Yes 2 No Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U5A Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. be filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 ☒ No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry land 2121 Elementary/Secondary (0-12) College (1-4or 5+) THGRADE CITYOF EACHER HOOL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should မ Davidoff Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health al
Important: If Item 27 Is
any injury or other trau EDWARDS-MANN(COUSIN AMBETH IERENA Baltimore, 20b. Place of Disposition (Name of cemetery crematory or other place in the cemeter) 11/17/2007 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lansdowne 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 2140 North Fulton Avenue MD 21217 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home Baltimore camo Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final iabetes 104 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner per Sequentially list conditions, if a second conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No for Month Year Day 4☐Pregnant at time of death 5 Other (specify) be detached 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1□ Yes 2X No this certificate or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 200 No 1 Tyes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier (s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0056316 m.b. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blvd. Baltimore, MD 1141 Security hris Park, m.D 31. Date filed (Month, Day, Year) 2. Registrar's Signature State NOV 0 7 2007 Registrar

DHMH 17 Rev 1/2001

kelbert 07-08542 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day November 3, 2007 0035 hrs Medical Examiner Robert Tyson 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Baltmore NA Johan Hopkins Hospital If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min Director 220-04-8604 Country) 1 X M 2 F Yrs 1-4-1983 Md. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location any 10b. County 1 X Yes 2 No ; 23a or 28a-f show e notified at once, or 28a-f show Md. NA Baltimore Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 3235 Elmora Ave. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, Armed Forces? White, etc. 1 XNever Married 2 Married Yes 2X No f Yes, Give Year Yes 2 X No specify: Widowed Divorced Specify: Black ⋧ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Elementary/Secondary (0-12) or other traumatic event, the Medical If item 27 is marked other than 12th grade Unemployed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Adrian Eugenia Tyson Dawson Be 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3235 Elmora Ave., Baltimore, Md. Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 crematory or other place) Removal from State Important: 11-10-07 Trinity Cem. Dundalk, Md. Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East 1101 E. North Ave., Baltimore, 21202) on 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Gunshot Wound to Back Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical ysician a burial -UNPENDED AMENDED #18. perFH.C873.11/13/07 TI Records, P.O. Box 68760, The law requires that the death certificate be phy: IF FEMALE 23d. Date of delivery If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has l death? performed' Yes 2 1 🗸 Yes Be

certificate the Hospital or Attending Physician: of Vital this After Division Director: I in by the f 24 hours after death.

26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other 4 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 Yes No 28a. Date of Injury (Month, Day,Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject was shot FOUND: Natural Yes 2 ✔ No Pending Nov 2, 2007 2128 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 3333 Elmora Avenue, Baltmore, Md. (Specify) Local Street determined 4 V Homicide 29a. Certifier 1

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated 29b. Signature and title of a

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of rson who completed cause of death (Item 23a) Deputy Chief Medical Examiner Jack Titus MD.

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

State Registra

Certification

Medical

(Check only

31. Date filed (Month, Day, Year)

NOV 0

Funeral

To the

November 3, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 = For State Registrar	State of Ma	ryland	/ Depa	rtmen tificat	t of H	ealth a D <i>eath</i>	ind M		giene Reg. No		07	35777
Physic		1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month 10 - 3	Da		Year 7	3. Time of Death
/Med Exami		Carl Elwood Temple 4a. Facility Name (If not institution, give st.				4b. City,	Town, or	Location o	f Death	10 5		. County		11.20 A
		Manor Care Rossvil	1e			Ва	1tim	ore				Balt:	imor	e
Funera Director		5. Social Security Number 6. Sex 112-22-2073	7. Age M 2□F	(In yrs. las	t birthday). Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day 8-13-1	h y. Year 926)	9. Birthp Cour	place (State or Foreign htry) MD
p .		Usual Residence of Decedent 10a, State 10b, County		10c City 7	Town or Lo	agtion							1	0d. Inside City Limits
aryla •ho	្ក													1 □ Yes 2 No
the N	Director	Maryland Baltimore		rerry	Hall	10f. Zic	Code				10a Ci	itizen of W	Vhat Cour	atry?
Sa or											•			,
Datailli Offe, Interpretation 2 12.13-0000 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, if a Medical Examinar must be notified at once.	Funeral	4323 Chapel Road 11. Marital Status 1 Never Married 2 Married 2 Married 12 Married 13 Married 14 Married 15 Ma	11. Marital Status 12. Was Decedent Ever in U Armed Forces?			Vas Dece Yes, spe	cify Cuba	n, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	Black, White, etc.			etc.
ural', c	d by	3 Widowed 4 Divorced	Year or Dates:			☐ Yes	ZINO	Specify:				Specify.	Whi	te
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filed Hygir ther		17. Father's Name (First, Middle, Last)			DIESE	:I Me	Ciraii		r's Name	e (First, Middle,	-			Company
id be fill ental Hyked oth	To Be	Charles Temple						Anna	Мар	Blakle	37			
shou and M mar		19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailin	g Address	(Street a			al Route Numbe	-9-	or Town.	State, Zip	Code)
and 2		Donald Temple(Son)			1613	Ang1	esid	e Roa	d Fa	11ston,	MD	210	047	
of He roth	-	20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☐ Re	moval from State	cen	ce of Dispo	natory or c	ther place			Date	20c. L	ocation -	City or To	own, State
Pag ment ant: I		4 Donation 5 Other (Specify)	movar nom State	St.	_			i		/2007	Ва	1time	ore,	MD
DEMITTION permit. Pages Depertment of Important: If it any Injury or once.		21. Signature of Funeral Service Licenses	Velle	عد				ss of Facilit	BCII	imunek Notting				
		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused to cause on each line	the death.										Approximate Interval Between
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/Medical		resulting in death)	Due to (or as a											
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Or VICAL F Physicien: Th this cartificate al director, pag	Be	25. Was case referred to medical examiner?						26. Place	of Deat	h (Check only o	one)			
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ding P. After 1 funera	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injun (Month, Day	Year) 2	8b. Time of Injury		28c. Injun Worl			28d. Describe	how inj	ury occurr	red	
VISION Attending ar death. ector: Afte	cati	2 Accident investigation 3 Suicide 6 Could not be	20 - Place of Iniv			М		Yes 2	No	70f Lagation /	Ctmata	and Alumb	20101010	al Route Number,
effar Olre	ertification;	4 Homicide determined	28e. Place of Inju building, etc.	. (Specify)	ie, iaini, sti	eet, ractor	у, опісе			City or To			Jei Gi Hui	ar noute Number,
To the Hospital or Attending I within 24 hours effect death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 certifying Physic (Cfleck only one) 2 dical Examin	ician: To the best o er: On the basis of and manner stat	examinatio	ledge, deatl on and/or in	n occurred vestigation	at the tin	ne, date an pinion, dea	nd place, ath occur	and due to the red at the time,	cause(date ar	s) and ma	anner as s and due t	stated. to the cause(s)
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ĕ 1 € 4	1	Down o	m MI	Λ			NE	1/9	79					Norma.
1		30. Name and address of person who cor	npleted cause of de	eath (Item 2	23a) (Type	Print)	ال ال <u>ا</u>		1-1	t	146	ンレ	الله (ا	UUY.
Q		Madai Chardo	े नेहर	15 (Dak	cod	9	d	Ste	100 @	bleu	B	irn	Se, HD
S Regis	tate trar	31. Date filed (Month, Day, Year) NOV 0 7 20	32. Registra	r's Signatu	K A	1342	ē							, , , , , , , , , , , , , , , , , , , ,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year **Physician** Samuel B. Thompson NOVEMBER 2007 0700 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown St. Mary's Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 8, 1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□F Pennsylvania 88 219-10-2489 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 1 ☐ Yes 2 ☐ No Director St. Mary's Charlotte HaLL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 29449 Charlotte Hall Road 20622 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: It Yes, Give Year or Dates: Korea <u>Ş</u> 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Military Career Army 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Homan Harry Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 46422 Sue Drive, Lexington Park, MD 20653 Dane A. Thompson, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ Removal from State New Canoe Creek Cem. 11/07/2007 Frankstown Twp, PA 4 ☐ Donation 5 ☐ Other (Specify) M01113 21. Signature of Fulleral Servi 22. Name and Address of Facility Sorge Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 422 N. Juniata Street, Hollidaysburg, PA 16648 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Shock Physician /Medical Due to (or as a consequence of) Examiner Preminana Sequentially list conditions, if the Ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and T Due to (or as a consequence of) SAMUEL BENJAMIN THOMPSON Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy performed? 2 🖳 1□ Yes or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 14 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. death. investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff

To the Funeral D

completely filled in To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEONARDTOWN MARYLAND 20650 RAKHI KRISHNAN MD

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



M- D -

29c. License number

D 60888

29d. Date signed (Month, Day, Year)

0

07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Marquerite M. Tribull 2:46 a. November 1, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Gilchrist Hospice Center **Baltimore** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months 74 Yrs 212-30-9523 Director February 10, 1933 Baltimore, Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h County show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 21043 U.S.A. 4844 Ilchester Rd items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 22 No 1 Yes Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White "natural" 27 is marked other than "natur r traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tony Dalfonzo Grace Lamertino ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4840 Ilchester Rd. Ellicott City, Maryland 21043 Ms. Grace Manger Daughter Important: If item any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 11/03/07 Baltimore, Maryland Loudon Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Brust **Physician** Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and -trans Due to (or as a consequence of): physician ar Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) been signed by the should be detached 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe page this certificate 2 **W**No or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSPILE 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural (Month, Day Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 式ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

P.O. | Records, Division or Vital thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu To the Hospital of within 24 hours af 0

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
>
> AANUN J. CHAMLES WY 6701 N. CHAMLES ST 70W 5W MD 21 204 31. Date filed (Month, Day, Year) 32 Registrar's Signature

State Registrar

29b. Signature and title of certifier

November 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:55 PM William Henry Watters October 31, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1137M 2□ F Director 103 215-32-0474 17, 1904 Maryland Apr. Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford Maryland Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 903 S. Fountain Green Rd. 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 10 (3) (07 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ğ Specify 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Laborer Farm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be ind Mental Samuel (unk) Watters Nellie (unk) (unk) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau once. Carol J. Burdette/Friend 903 S. Fountain Green Rd., Bel Air, MD 21015 20a. Method of Disposition
1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Hilltop Service Corp 11-3-07 4 □ Donation 5 □ Other (Specify) Towson, Maryland 21. Signature Fune Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications shock, or heart failure. List only on ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardio Vascular Disease **Physician** 50 years /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): the burial-transit Due to (or as a consequence of): attending physician Physician/Medical as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has death? 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 TYes 2 No 2 1 Inpatient 2 X ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation Injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Fallston, Maryland 2303 sobert

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

2007

NOV 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 WOODHOUS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILHCREST CENTER HOSPICE IOWSON BALTIMORE 8. Date of Birth (Month, Day, Year)

AUG, 23,1918

9. Birthplace (State Country)

VIRGINIA Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any high or other traumatic event, the Medical Examiner must be notified at 28a-f show Yes 2 No MD **Funeral Director** BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code WABASH AVE. 21215 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Year or Dates: UNK Race - American India Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) on and 2 should be filed within it Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION EDUCATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH WOODHOUS, SOPHRONIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3406 WABASH UCILLE WOODHOUS AVE. BALTO, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State RIDGE 21. Name and Address of Facility MILLER'S METROPOLITAN 4 Donation 5 Dother (Specify) of Furneral Service 21. Signature 1639 N. BROADWAY BALTO. MD 21213 CHAPEL Part1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** read disease or condition resulting in death) /Medical Due to fr as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and ched for use as the bunal-transit Due to (or as a consequence of): Moodhous Sr, Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 No 2 ER/Outpatient 3 DOA ပ this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After 5 Pending investigation or Attending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 5, 2007 who completed cause of d. (Item 23a) (Type, Print)

Registrar

State

2007

November 4,

6701 2. Registrar's Signature Balto Md 2120x

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Robert Leo Wiseman 8:30 a. /Medical November 5, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Howard 8350 Grove Angle Rd. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 215-14-4344 Maryland January 20, 1924 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Ellicott City Maryland Howard Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21043 U.S.A. 8350 Grove Angle RD Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 1943 ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White 'natural". 1946 Completed it of Health and Mental Hygiene.
If Item 27 Is marked other than "natu or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Gas & Electric **Building Services** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Roderick George Paul Wiseman ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5809 Victor Dr. Sykesville, Maryland 21784 Mr. Robert P. Wiseman Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important; If any Injury or once, 11/10/07 Sykesville, Maryland Lakeview Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to infine nate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last utile to for as a consequence of) Examiner The law requires that the death certificate be executed burial-trans Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Tes 2 🗌 No 3 Probably 4 □Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be funeral director 26. Place of Death (Check only one 2[No Hospital: Other: 4 ☐ Nursing Home 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify) Certification: To this 27. Manner of Death

Natural

Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death.

Director: A 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral C edical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29b. Signature and title of pertifie 29d. Date signed (Month, Day, Year)

12

State Registrar 30. Name and address

erson who completed cause of death (Item - Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

a 195094 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Doris Elizabeth Z		Sta	te of Maryland	/ Depai	rtment of	Health	and	Menta	al Hyg	giene		007	35781
	F	- For State egistrar I. Decedent's Name (First, Middle	Last)	Cen	ificate of	Deain				Date of Deat	eg. No. h		ime of Death
Physicia Medical Examir		Doris E. Zaiko								Month November	Day Yea 2, 2007	1	630 hrs
pt		4a. Facility Name (if not institution	, give street and number)			4b. City, To		ocation of	Death		4c. County o		
		11610 Stocksdale Roa				Kingsv		I (C) Desiles	0411	0. Data of Ric	th (MM/DD/YYYY	e County	e (State or
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Aaryla 28a-f	Director	10e. Street and Number 10f. Zip Code								1	0g. Citizen of Wh	at Country?	
sath with the Maryland items 23a or 28a-f show nst be notified at once.		11610 Stockda	le Road				087				U.S.A.		ndian, Black,
th with	Funeral	11. Marital Status 1 Never Married 2 Ma	12. Was Decedent	?		as Deceden es, specify				cify Yes or No ican, etc.)	White		nulan, black,
rer dea			1 Yes 2 orced If Yes, Give Year	X No	1	Yes 2	X No	specify:			Specify:	White	
ours af	d b	15. Decedent's Education (Spec	or Dates:	mpleted)	16a. Deceder	nt's Usual C					16b. Kind of Bu	siness/Indus	itry
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Completed	12 17. Father's Name (First, Middle,	Lost		IIome	maker	11	8.Mother's	Name (First, Middle,	Maiden Surname	Home	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	TO E	19a. Informant's Name/Relationsh	ip (Type, Print)					and Numb	er or Ru	ıral Route Nur	mber, City or Tow		
MD id 2 sho lith and m 27 is aumati		Anthony Zaik	o (nephew)	1	2337	Penni	ngto	on Ro	ad -	- Bel A	ir, Mar	yland_	21015
ore, s l an of Hea		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from S	state	Place of Dispo crematory or o	ther place)							
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Baltimore, permit. Pages I are Department of He. Important: If ite injury or other tr	-	S nature of Funeral Service	Licensee		122.	Name and A	address	or racility	E. F	'. Lass	sann Fune	eraı n Marvla	ome, P.A. and 21087
Physician	-	23a. Part I. Enter the disease, or	complications that cause	d the death	. Do not enter	the mode o	f dying,	such as ca	rdiac or	respiratory ar	rest, shock, or he	eart A	pproximate Interval Between Onset and
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taminer		or condition resulting in death) Due to (or as a consequence of):											
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	nine	Cause. Enter Underlying Cause (Discoso or injury that initiated C.											
isi e V	Examine	events resulting in death) Last	Due to (or as a con	sequence o	f):								
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	Physician/Medical	IF FEMALE:	23c. If yes, outcome	ome of preg	nancy			- 27	-		23d. Date of	•	
Vital Records, P.O. Box 68760, hysician: The law requires that the death certificate be this certificate has been signed by the attending physical director, page 2 should be detached for use as the bur	ian/	23b. Was decedent pregnant in the past 12 months?	T LITTE BITCH	at time of de		etal death	3	Ectopic	pregnar	ncy	Month	Day	Year
Sox death of e atten for us	ysic	1 Yes 2 No 9 Uni			2 (Other (Spec							
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Division of Vital Records, ral or Attending Physician: The law requirens after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	မ	1 ✓ Yes 2 No 27. Manner of Death	1 111pa	tient 2	ER/Outpatie 28b. Time o			ry at Work			e how injury occu		
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risic r Atte ter dea irector	ficat		stigation 28e. Place of	Injury - At h	nome, farm, str	eet, factory	, office b	uilding, et	tc.	28f. Location or Town		ber or Rural	Route Number, City
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying P	hysician: To the best of aminer: On the basis of ex	my knowled	dge, death occ	curred at the	e time, da	ate and pla	ace, and	due to the ca	use(s) and mann te and place, and	er as stated. I due to the c	ause(s)
To the withing To the complete complete the the complete	Medical	one) 2 ✓ Medical Example 29b. Signature and title of certific	and manner state	ed.	and/of investig			e number			29d. Date sig		
	2	290. Signature and title of certific	17/		_		O.C.		OCN	1E	Novembe		
		30. Name and address of person	who completed gause c	of death (Ite	m 23a)					_			
10		Theodore M. King, Jr				111 P	enn St	reet, Ba	altimore	e, MD 212	01		
S	tate	31. Date filed (Month, Day, Year,	7 2007 32 Regis	trar's Signa	ture	TAN D							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physic	cian	1. Decedent's Name (Fi		Austin							2. Date of De Month NOVEMbe		200 ′7 °		of Death	
/Med Exam	lical	4a. Fecility Name (If not					4b. Cit	, Town, or	Location of				County of Deat	163	2 141	
Lxaiii	irici	Harford M						Havre		Grace			Harfo	rd		
Funera		5. Social Security Numb	10	7. Age		last birthday) Yrs.	If Und Months	or 1 Year Days	If Under Hours	24 Hrs.	8. Date of Bir (Month, Da 11/23/	th ly, Year)	_ Co	hplace (Statuntry)	e or Foreign	
Directo		212-52-81 Usual Residence of Dec	edent))							11/23/	1940	VIL	ginia		
larylar ehow	7		b. County Harfor	a		y, Town or Lo rdeen	ocation								City Limits es 2 ☐ No	
the N	rect	MD 10e. Street and Number		u j	Ace	Laeen	10f. Z	ip Code				10g. Citi	zen of What Co			
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Iryland 21215-0036 should be filed within 72 hours after deeth with the Maryland of Mental Hygiene. marked other then "naturel", or items 23a or 28a-f ehow matic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ②	2 Married	12. Was Decedent E Armed Forces? 1 Yes 22 N If Yes, Give Year or Dates:	J.S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt 1 Yes 2020 Specify:			n, Puerto R	Puèrto Rican, etc.)			ace · American Indian, lack, White, etc. city: White				
Maryland 21215-0036 nd 2 should be filed within 72 hours att tilh end Mental Hygiene. 27 is marked other then "naturel", or traumatic event, the Medical Event reaumatic.	Completed	(Specify only highest grade completed) (Give k Elementary/Secondary (0-12) College (1-4or 5+)						lent's Usual Occupation 16b. kind of work done during most of working 20 NOT use retired)						. Kind of Business/Industry		
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Mary and 2 sho aith end 27 is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State										a, <i>Zip Cod</i> e) 21001				
Baltimore, Marylar permit Pages 1 and 2 should be Department of Health end Menta Important: if Item 27 is marked any nijury or other traumatic events.		20a. Method of Disposit 1 ⊠Burial 2 □ Cr 4 □ Donation 5 ☑	remation 3 🗀 🤁	emoval from State	0	lace of Dispo emetery, cred stin F	matory or	other place		11/8/0)7		cation - City or La, Vir			
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Div To the Hospital or / within 24 hours effer To the Funerel Dire completely filled in b	edical	29a Certifier 1 (Check only one)	Certifying Phys Medical Examin	ner: On the basis of and manner sta	examina	wladge, death tion and/or in	h occume vestigatio	d at the two	e date an inion, dea	ath occurre	nd dua to the d at the time,	date and	and macrist at place, and due	stated to the caus	e(s)	
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DHMH 17 Rev 1/2001

1632

Austin, Kenneth

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Arlington Hooper Adkins October 21 2007 9:00 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Chesapeake Woods Center Cambridge If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2 □ F Director 214-07-8081 92 18, 1915 Maryland Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28a-f show Examiner must be notified at Dorchester 1 ☐ Yes 2 TXNo MD Cambridge Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2934 Old Route 50 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. Armed Folces: 1 TXYes 2 ☐ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No white Specify: 3 □Widowed 4 □ Divorced Item 27 is marked other than "natural", other traumatic event, the Medical Exa Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) mechanic city government 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Be Samuel Hooper Adkins Mary Frances Lankford Department of Health and 1 mportant; If Item 27 is man 1 iv injury or other 1 is 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Arline Chase daughter 2934 Old Route 50, Cambridge, MD 21613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 10/24/07 Spedden Seward Cem. Cambridge, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee B-K.B 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician rie 10A(disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncoming Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): the burial-Box 68760, physician pe Physician/Medical as 1 attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ 10 24a. Was an was and autopsy performed? has page certificate 1□ Yes Physician; director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA ၉ After this funeral 27. Manner of Doth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Natural Injury To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

State Registrar 29b. Signature and title of certifier

address of person wh

30. Name

31. Date fil

100 Branble

29d. Date signed (Month, Day, Year)

and manner stated.

pleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Bouldi 4c. County of Death Oct 2:00 A M Mary ING /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Easton If Under 1 Year | If Under 2 Hospice -Talbot 8. Date of Birth (Month, Day, Year) July 18,1949 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 📭 F Months Days Hours 218-50-1144 58 Director Maryland Usual Residence of Decedent death with the Maryland 10b. Count 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director Anne's Grasonville 10e. Street and Number 10g. Citizen of What Country? 502 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | D/No | If Yes, Give | Year or Dates: 21638 74. Race Completed by Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 is marked other than "natural", or ite 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 ☐ Widowed 4 ☐ Divorced Black Department of Health and Menta Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 homas Mazie Warrick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lemetery Road Grasonville, MD, 21638 (Name of Date 20c. Location - Otty or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/22/07 Grasonville MD. 4 ☐ Donation 5 ☐ Other (Specify) Robinson's Cemetery 22. Name and Address Facility Henry Funeral Home, P.A. 510 washington St. Cambridg 21. Signature of Funeral Service Licenses MD. 21613 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deat CHECK Immediate Cause (Final disease or condition resulting in death) Breast **Physician** cance /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for Month 5 Other (specify) 1 ☐ Yes No detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform To the Hospital or Attending Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 110 Other: 4 Nursing Home 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Mannel of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident (Month, Day Year) 5 | Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

To the Funeral Director: within 24

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

29c. License number

2330

29d. Date signed (Month, Day, Year)

07-08388

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 35788 Vincent Carroll Certificate of Death Reg. No 1- For State 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Month Day October 28, 2007 1030 hrs Physician/ Carrol1 **Medical Examiner** Vincent Carl 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 901 West University Parkway Apt. 2 A 9. Birthplace (State or 8. Date of Birth(MM/DD/YYYY) If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) Foreign Country)Wash. 6. Sex 5. Social Security Number **Funeral** Days Hours Min. Months DC 1987 7. 20 Jan. Yrs Director 1X M 2 F 578-13-6058 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Washington 23a or 28a-f show 10g. Citizen of What Country? D.C. hours after death with the Maryland Director 10f. Zip Code 10e. Street and Number U.S.A. 20015 4116 Legation ST N.W. 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral White, etc or items Armed Forces? 1 X Never Married Yes White Specify Yes 2 X No specify: "natural", or If Yes, Give Yeer Divorced Widowed 16b. Kind of Business/Industry other than "natural", the Medical Examiner 16a. Decedent's Usual Occupation (Give kind of work done ð 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed altimore, MD 21215-0036

mit. Pages 1 and 2 should be filed within 72 hot eartheart of Health and Mental Hygiene. Oretant: If item 27 is marked other than "nat my or other traumatic event, the Medical Exa College (1-4 or 5+) Elementary/Secondary (0-12) College 2 Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carolyn A. Johnson Gerard P. Carroll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) N.W. Washington D.C. 20015 4116 Legation ST. Gerard P. Carroll / 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Baltimore, Burial 2 X Cremation 3 Removal from State Falls Church, Va. Nov. 5,07 National Crematory Donation 5 Other Specify Joseph Gawler's Sons, 22. Name and Address of Facility 21. Signature of Funeral Service, Licensee 5130 Wisconsin Ave. N.W. Washington D.C. 20016 permit. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and 23a. Part I. Enter the **Physician** Death failure. List only one cause on each line Medical Acute alcohol intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Couse Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED 27,28a-f, perME, g873, 11/8/07 TT X UNPENDED s been signed by the attending physician should be detached for use as the burial -23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy Year IF FEMALE: Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 V Unknown Records, P.O. à 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy performed? death? 2 No certificate has 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Other₄ Nursing Home 5 Residence 6 Other: Scene Division of Vital Hospital: 1 examiner? DOA inpatient 2 FR/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year 27. Manner of Death Certification: Yes 2 X No unk Natural Fnd 10/28/2007 Fnd 10:00 am Pending death. Director: I in by the f 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Baltimore, 901 W. university Pkwy. Apt in by 6 X Could not be after 3 Suicide (Specify) found in house To the Hospital within 24 hours a To the Funeral L Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 (Check only one) 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 29, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD. 31. Date filed (Month, State Registrar

ORIGINAL

State Registrar 31. Date filed (Month, Day, Year) 0CT 3 0 2007

28, 2007

OCTOBER

MICHAEL CRAWFORD

Registrar's Signature

		Please	Type or Prin				-	_	ible.		
		For State Registrar	State of Ma		partment of F ertificate of			giene Reg. No. 2	007	35790	
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IOTE, INICITYICILL ZIZID-UUSO ges 1 and 2 should be filed within 72 hours after death with the Maryland ti of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funera	11. Marital Status 1 ▼ Never Married 2	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13	3. Was Decedent of H If Yes, specify Cub 1 □ Yes 2 No		pecify Yes or No to Rican, etc.)	Spec	ack, White	ican Indian, , etc. HITE	
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and 2 should and 2 should lealth and Men m 27 is marke her traumatic.	T	19a. Informant's Name/Relationship (Type. Print)		ailing Address (Street					ip Code) 21502	
Pages 1 and nent of Health int: If item 27 iry or other to		20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cemetery, c	position (Name of rematory or other pla		Date 2/2007	20c. Location	1	rown, State	
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rtiffical	Be C	25. Was case referred to medical examiner?				26. Place of Dea		one)	1 ☐ Yes	2□ No	
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tal or Att s after de al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ury - At home, farm, c. (Specify)	street, factory, office			(Street and Nun wn, State)	nber or Ru	ral Route Number,	
To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)	nysician: To the best miner: On the basis of and manner sta	fexamination and/orated.	investigation, in my	opinion, death occ	urred at the time	, date and place	e, and due	to the cause(s)	
/	Ž	29b. Signature and title of certifier	0		29c. Licens	se number	٥,	29d. Date sign	ned (Month	n, Day, Year) i, 2007	
6		30. Name and address of person who	completed cause of d	eath (Item 23a) (Typ	e, Print)	0 > 5 < 8				, 200 1	
7723		Sunil Gupta M 31. Date filed (Month, Day, Year)	D 625	Kent 1	Venue	Cumpe	rland	, Mary	Mana		
Sta Registr		QCT 2 2 20	07 Silver	J. B. B.	berte						

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 10 2007 5:35 P^M Lucille Anne Cole 23 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Coastal Hospice at the Lake Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/12/1942 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F 178-32-4048 64 PA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1X Yes 2 No Director MD Worcester Ocean City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 injury or other traumatic event, the Medical Examiner must be recons. 131-2 Newport Bay Drive 21842 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married ^{Specify:}White altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Secretary |Federal Gov. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Kolick Dorothy McCaslin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William O. Cole Sr. 131-2 Newport Bay Dr., Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 10/30/07 Dagsboro, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 William Street, Berlin, Maryland 21811 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Netastatic **Physician** Neuroendocizine lyear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusito (or as a consequence of). Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician the attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1Ransplant 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autoper performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospics in patient 1 Yes > No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Telegratifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely f (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D30619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA10 Beelin MD 21811 Abbott MO 10445 Ocean City BIVD Suite 1 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 25 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 3:20 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2007 **Physician** John Melvin Cheseldine October 0 31. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown 8. Date of Birth (Month, Day, Year)
July 15,1927 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 80 Maryland 578-42-6669 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at annew. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2√XNo **Funeral Director** Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21585 Peabody Street 20650 USA 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Painting Company Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes G. Bowles Richard Benjamin Cheseldine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Regina Ann Foote / Daughter P.O. Box 2544, 23285 Point Lookout Road, Leonardtown, Maryland November November 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Metropolitan Crematory 1, 2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Sima ure of Funeral Service Lice 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part. Enter the disease, or compilirations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 20 /Medical Due to (or as a cons quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Tes 2 No 3 Probably 4 Unknown has been signed to should be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate ha perform 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: Lo 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 @ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of cer 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

OP. T 3 1 2007

30. Name and address of person who completed car

James P. Jarthoe, M.D.

Brew & Species

e of death (Item 23a) (Type, Print)

24035 Three Notch Road, Hollywood, Maryland 20636

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

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egistrar's Signature

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ZUO, FRADMICK, MD 7/702

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Phys /Me	cian dical	PAUL	EN	GLAND		Month 10	Day Year 17 200	
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Directo		168-03-7541 ^{1⊠M 2□F}	91 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day,) PR • 23,	1916 PE	INSYLVANIA
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d 21215-0036 filed within 72 hours after death with the Maryland Hygiene, ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 220 DONAHUE MANOR ROAD		10f. Zip Code 15522		100	J. Citizen of What C U.S.A.	ountry?
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Baltimore, Permit. Pages 1 a Department of Hee mportant: If Item nny Injury or othe		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	EVERETT (matory or other pla	^{ce)} 10/22/		EVERETT,	
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/Medica	d	disease or condition resulting in death) a. A Due to (or as a	a consequence of):	Failur	·e			
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uted I Insit	Examiner	Sequentially list conditions, if the list conditions, if the list conditions, if the list conditions cause. Enter Underlying Cause (Disease or injury that initiated events	a winse guence of r					
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nd		30. Name and address of person who completed cause of do Beverly M. Calkins A		Print)	morial,			

		1	For State Registrar	State of Maryla		artment of			giene Reg. N2007	35795
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ar garage	4	-	Wilson Health Care			Gaither If Under 1 Yea			Montgome	
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5-0036 72 hours after death with the Maryland natural, or Itema 23a or 28a-f show	Xaminer	by Funeral	11. Marital Status 1 Never Married 2 Married 3XX Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🛣 N	f Hispanic Origin? (suban, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Specify: Wh	te, etc.
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Maryland 2121 nd 2 should be filed within Ith and Mental Hygiene. 27 is marked other than	atic ever	m	17. Father's Name (First, Middle, Last) Arthur Priest				Marga	reth Wag		
Mar nd 2 sh alth and 27 is m	traum		19a. Informant's Name/Relationship (Type	(Daughter) 19b. Maili				er, City or Town, State. FL 34232	Zip Code)
D age	or other traumatic	1 1	Carolyn Porter McGa 20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Re	20b. emoval from State	Place of Dispo cemetery, cre	sition (Name of matory or other p	lace)	Date	20c. Location - City or	
Baltimore, permit. Pages 1 a Department of Hei Important: If Item	any injury once.	Ì	4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	/ 1	ropol:	Ltan Cre 2 Name and Add 2 East D 2 ithersh	matory 10 fress of Facility De eer Park	Vol Fune Drive	Alexandria eral Home	, virginia
Pnysic	983 N		23a. P. n1. Enter t. e disease, or complice hock, or he nt failure. List only on	cations that caused the de e cause on each line.	ath. Do not en	er the mode of d	ying, such as cardia	ic or respiratory a	rrest.	Approximate interval Between Onset and Death
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BOX death cert	for use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	tal death 3	□Ectopic pregnar □ Other (s <i>pecify)</i>			23d. Date of de Month	Blivery Day Year
S 8 8	9	ρ	Part fl. Other significant conditions con	tributing to death but not re	esulting in the u	inderlying cause	given in Part f.	23e. Did 1	tobacco use contribute Yes 2 ☑No 3 ☐ F	to the cause of death? Probably 4 Unknown
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~			30. Name and address of person who co	BIRSCHO	Alet.	Print)	80/10 64/T/1	2 CRSS	ELLAVE, NO	SNUS 20017
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Registrar

2007 35797 State of Maryland / Department of Health and Mental Hygiene Emma Darlene Griffiths 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 31, 2007 Year 1218 hrs Medical Examiner Griffiths Emma Darlene c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Somerset Princess Anne 33440 West Post Office Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Country) Maryland Director 11/08/1951 218-62-4227 55 Yrs. M 2XF Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 No Princess Anne MD Somerset 23a or 28a-f show notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 33440 West Post Office Road 21853 14 Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married 2 X No Yes White Yes 2 No specify: Specify: If Yes, Give Year 3 Widowed Divorced ⋧ 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) . Pages 1 and 2 should be filed within 72 hours then of Health and Mental Hygiene. Tant: If item 27 is marked other than "nature or other traumatic event, the Me lical Ex mi ted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Comple Griffiths Properties Baltimore, MD 21215-0036 10 none Property Manager 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul Black Darlene Puckett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Loxahatchee, FLA 33470 15705 61st Place North, Patricia Bonincontri/daughter 20c, Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Number 2 Cremation 3 Removal from State Friendship U.M. Cem. 11/4/2007 Eden, Maryland Donation 5 Other Specify. 22. Name and Address of Facility
Hinman Funeral Home 2 . Signature of Funeral Serv - jcensee M00295 MD 21853 11673 Somerset Ave.. Princess Anne Approximate Interval Part | Enter the dillearle, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Drowning complicated by meperidine and fentanyl use Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): 1d events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED by the attending physician ached for use as the burial AMENDER II, 27, 28a-f, perME, C874, 12/13/07 TT Box 68760 23d. Date of delivery IF FFMALE 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Ectopic pregnancy Month Dav Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Linknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 0 Yes 2 No 3 Probably 4 ✔ Unknown Þ Atherosclerotic cardiovascular disease, clinical history of lung Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of cancer autopsy performed? death? certificate has 1 🗸 Yes No ✓ Yes 2 rrospital or Attending Physiciau: Th within 24 hours after death. To the Funeral Direct 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other 7 Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 No 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: Natural 1 Yes 2 X No subject drowned Pending Fnd 10/31/07 Fnd 12:00 pm 2 X Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide State)

Nost Office Road Princess 33440 W. determined residence (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 1, 2007 O.C.M.E. Inconti, Mis Doma My 0 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 32. Regi ar's Signature 31. Date filed (Month, Day, Year) State NOV 05 200 Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #s 4c, 23b, 26; per phy., 10/22/07, State of Maryland / Department of Health and Mental Hygiene Allegany Co. 1- State Registrar Certificate of Death Reg. No 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year Month Day **Physician** 1336 (M 20 2007 10 /Medical 4c. County of Death Allegany 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Comberla Memorial HOS 14a1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Hours 61 12/05/1945 Director 219-44-0910 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Inity or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MD Allegany Cumberland 10e. Street and Number 11511 Valley Road 10f. Zip Code 10g. Citizen of What Country? 21502 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 No 1967 — If Yes, Give Year or Dates: 1070 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. <u>ک</u> 3 Widowed 4 Divorced 1970 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Superintendent Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles John Hout Daphne Virginia Plummer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paulette Hout / Wife 11511 Valley Road, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory 10/22/2007 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 21. Signature of Juneral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** oronon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner the death certificate be executed and use as the burial-tran Due to (or as a consequence of) attending physician for use as the burian Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown this certificate has been 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Scheening Home 6 Other (Specify) 2 No 1 ☐ Yes 2 XER/Outpatient 3 □ DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No within 24 hours after death

To the Funeral Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nes DLZ - Memorial 31. Date filed (Month, Day, Year)
OCT 2 2 2007 Registrar's Signature State Registrar

07-08431 Ashley Hazell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

2007 35799

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Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day	Year	3. Time of Death
edical Exami		ASHLEY LAUREN HAZELL	O'l To and a story of Partit	October 30, 2	007 4c. County of Death	0630 hrs
		Facility Name (if not institution, give street and number) Washington County Hospital	 City, Town, or Location of Death Hagerstown 	1	Washington	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	,	M/DD/YYYY) 9. Birth Foreign	
Director		219-51-1710 1 M 2XF 9 Yrs.	Months Days Hours Min	FEB. 4,	1998 Co.	intry) MARYLAND
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vith the Maryland s 23a or 28a-f show a notified at once.	Director	8429 NORMAN COURT	21733	Tog. c	U.S.A.	
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	
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To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated 29b. Signature and title of certifier	29c. License number		9d. Date signed (Mo	
	_	70/	O.C.M.E.		October 31, 200	
		30. Name and address of person who completed cause of death (Item 23a)				
		,	in Street, Baltimore, MD 2	21201		
S	tate	31. Date filed (Month, Day, Year) 32. Redistrar's Signature				

			For State Registrar	State of Mary		artment of F <i>rtificate of</i>		Mental Hy	giene Reg. No	007	35800
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	items	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or Norto Rican, etc.)	0- 14. F	Race - Ameri Black, White	
39	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medieal Examiner must be notified at	þ	1 ☐ Never Married 2 🔯 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 □ Yes 2 🗓 No	Specify:		Spe		.ack
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פֿר	ages 1 nt of H : If ite		20a. Method of Disposition 1	Removal from State		natory or other pla	i i	Date	20c. Locatio	,	,
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer	1		Peace Cer . Name and Addre		03/2007			
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ŏ	death certific attending pl	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pr		Ectopic pregnanc	,		23d.	Date of deliv	
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<u>Т</u>	that the		Part II. Other significant conditions of	ontributing to death but not	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?
Vital Records,	quires n sign	d by						10	Yes 2 ₩	5 3 □ Pro	obably 4 ∐Unknown
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	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier (Check only one) 1	ysician: To the best of my niner: On the basis of exam and manner stated.	mination and/or in	vestigation, in my	opinion, death occ	e, and due to the curred at the time	, date and plac	manner as ce, and due	to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licens		T	29d. Date sig	ned (Month	n, Day, Year)
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			30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print) Rys Ko	SDITAT	win	JARN T	Sain	MD
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S		/) /(, -0-7			· ''
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State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 24, 2007 Donna Louise Homrig 4:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 11204 Midvale Road Kensington Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Nov 28; 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2**X** F 1929 Illinois Yrs. 361-20-7487 77 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 GYes 2 ☐ No MD Montgomery Kensington or 28a-f the Medical Examiner must be notified Direct 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 11204 Midvale Road 20895 USA items 23a death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White þ 3 ☐ Widowed 4 X Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manicurist Beauty Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I John Donato Myrna Monson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Dreyer/daughter 11204 Midvale Road Kensington, MD 20895 item 27 ls Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If ite 1 Burial 2 Cremation 3 Removal from State Depertment of Important: If any injury or once. Chesapeake Crematory 10/25/07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signatur of Funeral/Service Licer MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischaemic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physicien and detached for use as the burial-transit thet the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown es been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 5 Yes 2□No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate hes autopsy page relucion any 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes _ 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No in by the Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funeral Direct 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 231 (S) 12 ne and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 9406 Old Georgetown Rd. Bethesda, MD 20814 Gita C. Bakshi, 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State OCT 2 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35802 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 WILLIAM IZZETT NOVEMBER 03:10 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MEMORIAL HOSPITAL ALLEGANY CUMBERLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 3, 1952 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** Hours Days 1 M 2 □ F МD 220-58-0040 Director 55 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Cumberland Y☐Yes 2☐No MD Allegany Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 235 Paca Street death \ Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white ģ 3 ☐ Widowed ▶☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) n/a Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Jean Emma Izzett James Robert Izzett ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 a\/ale MD 21502 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any Injury or other traconce. son Erik Kahl 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/10/2007 MD Scarpelli Funeral Home, P.A. Cresaptown 4 Donation 5 Dother (Specify) 21. Signature of uneral Service Licentee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lisyonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) a ANOXIC ENCEPHALOLOGY /Medical Due to (or as a consequence of): **Examiner** b. RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed PULMONARY EMBOLISM Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DIABETES MELLITUS, CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ⋈ No CORONARY ARTERY DISEASE autopsy performe 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Npatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

BEVERLY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32 Registrar's Signature

CALKINS, M.D.

D54411

500 MEMORIAL AVENUE CUMBERLAND, MD 21502

NOVEMBER 2, 2007

Physician /Medical **Examiner** burial-tran and nding physician ause as the burial Division or Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

10a. State

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Opertment of Health and Mental Hygiene. The Unportant; if theat 1st marked other than "natural", or items 23a or 28a-f show any injun; if item 27 is marked other than "natural", or items 23a or 28a-f show any injun; or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

To the Hospital or Attending death. Director: within 24 hours a To the Funeral C

Immediate Cause (Final disease or condition resulting in death) Co-quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>^</u> Completed 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be Hospital: Other: 4 Nursing Home 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5/1/20 4 Certification: 5 ☐ Pending investigation 1 Natural 10/08/2007 A W 2 **₩**No 1 Tyes 00 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Pockurile, mp 20958

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) D65485 10-19-07

Dupomile 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road, Silver Spring, MD 20910 Barbara A. Supanich, M.D.,

State Registrar

31. Date filed (Month, Day, Year) OCT 2 4 2007

Jurbara



State of Maryland / Department of Health and Mental Hygiene 35804 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 5:30 p.M CLARENCE EUGENE LEATHERMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Somerford Place Frederick If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 1 XM 2□ F 220-28-3496 83 Director July 18, 1924 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10b. County 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Myersville Maryland | Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11110A Harp Hill Road 21773 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black. White, etc. 1 ☐ Never Married 2 X Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) Farmer Agriculture permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar George Leatherman Edna Hazel Brandenburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glendoris Leatherman/wife 11110A Harp Hill Road, Myersville, Maryland 21773 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Grossnickle Brethren Nov. 7, 2007 Myersville, Maryland 5 ☐ Other (Specify) 4 □ Donation uneral Service Licensee 22. Name and Address of Facility 21. Signature of 504 Main Street Ricketts Funeral Home Myersville, Maryland21773 avella a Approximate Interval Between Onset and Death 23a. Part1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 341 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-tran To the Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical use as IF FEMALE If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy after for u Month in the past 12 months? Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐Unknown certificate has been si irector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 27 No 4 Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Many er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D16935 BZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael R. Behre, M.D., South Church and Franklin Sts., Middletown, MD 21769 NOV 0 32. Registrar's Signature 31. Date filed (Month, Day, made State 7 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

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2			19a. Informant's Name	/Relationship	(Type. Print)		19b. Mail	ing Address (Stree	t and Number or Rur	al Route Numb	er. City or To	own. State. Zi	in Code)	
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berland, MD 21502 Approximate Interval Between Onset and Death tory arrest, 23d. Date of delivery Month Year Did tobacco use contribute to the cause of death? 1 Yes 2 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1. Natural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1trepresentation of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

To the Hospital or Attending Physiclan: The law re within 24 hours after death.

To the Funeral Director: After this certificate has bee completely filled in by the funeral director, page 2 sho Division or Vital Reco

Be

Medical Certification: To

nas

State Registrar 31. Date filed (Month, Day, Year) OCT 2 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

One of the print of the

32 Registrar's Signature

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Drive, Cumberland, m/

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	Physici /Medic		Dennis R. Lilly					Month	Day ber 18, 2007	Year	07:50 PM ^M
	Examin		4a. Facility Name (If not institution, give street	et and number)		4b. City, Town, or	Location of Death		4c. County	of Death	071301111
			23 West First Street				Cumberland		Allega		
	Funeral Director		5. Social Security Number 6. Sex 1 M M	2□ F 7. Age (In yrs. 59	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da December	y, Year)	Cour	place (State or Foreign htry) yland
	and w		Usual Residence of Decedent 10a, State 10b. County	10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
	Maryl f sho ied at	힏	Maryland Allegany	C	umberland	1					1 XYes 2 □ No
	r 28a-	Director	10e. Street and Number 23 West Fir			10f. Zip Code			10g. Citizen of W	hat Cour	ntry?
	th witl 23a o ust be	a D	25 West FII	st Succi		21502-			U.S.A.		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	4	Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race	- Americ	an Indian, etc.
0000	's afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 (No If Yes, Give Year or Dates:	1	☐Yes 2 No	Specify:		Specify:		
Ş	thour attural	edk	15. Decedent's Education	on	16a. Deced	ent's Usual Occup	ation	-	16b. Kind of Bu	Whi:	
ה ה	hin 72 9. In "ne Medic	plet	(Specify only highest grade co	mpleted) College (1-4or 5+)	I (Give	kind of work done of NOT use retired	during most of work	ing	Too Killia of Da	3.11000/ H N	adony
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<u>8</u>	ould Men narke	은	George W. Lilly, Sr.		1 .2			e June Elri			
<u>0</u>	d 2 sł th and t7 is r traur		19a. Informant's Name/Relationship (Type.	sister			and Number or Run				21545-
ני	s 1 an F Heal Item 2 other		Mary Teter 20a. Method of Disposition	20b. F	Place of Dispos	Bruce House sition (Name of	1 [unt Savage	20c. Location -		
	Pagesent of or or or or or or or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State		natorý or other plac l Crematory	i i	ber 19, 2007	Cumberla	nd Ma	arvland
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۵	B E E		John K. A	Jurs		Durst Funer	ral Home, 57	Frost Ave.	, Frostburg,	MD :	21532
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as a second state of the complex of the	ons that caused the deat ause on each line.	h. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory ar	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	metastat:	ic pro	state c	ancer			ur	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						
uš.	A CS S	ē	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying	Due to (or as a conseq	uence of);						
	uted d ansit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c								
'n	exec an and rial-tra	Еха	resulting in death) Last	Due to (or as a conseq	uence of):						
0/00,	icate be executed physician and the burial-transit	dical	d								
5	ertifica ing ph e as ti	Med	IF FEMALE:								1 50 51 5
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	f yes, outcome pf pregna 1☐Live birth 2☐Feta	il death 3□	Ectopic pregnancy			23d. Date Mor		ery Day Year
j	the de	ysic		4∐Pregnant at time of c 9⊡Unknown	ieath 5∟	Other (specify)					
	that ned by deta		Part II. Other significant conditions contributions	uting to death but not res	ulting in the un	derlying cause give	en in Part I.	23e. Did to	obacco use contri	bute to th	ne cause of death?
מ כ	quires in sign	ed by						1 🗆 1	Yes 2 □ No	3 ☐ Prob	ably 4 🛣 Unknown
	aw re Is bee 2 sho	Completed						24a. Was	an 24b. V	/ere auto	psy findings available mpletion of cause of
	The I	mo						autor perfo 1⊟ Yes	rmed? d	eath?	mpletion of cause of 2□ No
0	clan: ertific octor,	Be	25. Was case referred to medical examiner?				26. Place of Death				
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5	ding I	ion	1 Natural 5 ☐ Pending	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ `	/ at <br Yes 2 □ No	28d. Describe h	now injury occurre	ed	
2	Atten death ctor: y the	ficat	a Could not be	8e. Place of injury - At ho	ome, farm, stre			28f. Location (S	Street and Numbe	r or Rura	l Route Number
2	al or / after I Dire d in b	Certification:	4 ☐ Homicide determined ☐	8e. Place of injury - At ho building, etc. (Specif	y)	- ·, · · · · · · · · · · · · · · · · · ·		City or Tou	vn, State)	, or mara	rriodio (Vambol,
	ospita hours unera ly fille		29a. Certifier (Check only Certifying Physicia Check only Check	n: To the best of my kno	wledge, death	occurred at the tin	ne, date and place,	and due to the	cause(s) and mar	ner as s	tated.
	the H nin 24 the Fu	Medical	one)	and manner stated.	uon and/or inv			red at the time,	date and place, a	nd due to	the cause(s)
		2	29b. Signature and fitle of certifier	4		29c. License			29d. Date signed		Day, Year)
	-8	,					60478		10/19,	/ / /	
	2/1		30. Name and address of person who complete the second sec	eted cause of death (Item	1 23a) (Type, F	Print)	m 0/0.1	inat	715-	0.0	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature .	Lance) CLITTO	mo.	545	Ud-	7
	Registra		OCT 2 2 2007	Barre	the Son	wil					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** October 28, 2007 Katherine Susan Lambert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Marv's St. Mary's Nursing Center Leonardtown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, June 3, **Funeral** Months Days Hours 1 M 2 YF 76 1931 Kentucky 217-26-3731 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2√ No Director Charles Maryland Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 110 Jefferson Street 'natural", or Items 23a 20602 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates: White Completed or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Callege (1-4or 5+) Nursing Assistant Nursing Home Pages 1 and 2 should be filed vent of Health and Mental Hygicint: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roy Virgil Toler Lilly Mae Hoskins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15245 Oaks Road, Charlotte Hall, Maryland 20622 Irene T. Potthast / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite October 1XXBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) Charles Memorial Gardens 30, 2007 Leonardtown, Maryland 22. Name and Address of Facility Mattingley—Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the diseas , or communations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each like. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consec **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Vear Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 ☐ No 1 Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient ပ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No nin 24 hours after death. the Funeral Director: A 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 240\$5 Three Notch Road, Hollywood, Maryland 20636 James P. Jarboe M.D. 31. Date filed (Month, State 2007 Registrar

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Registr	rar			color and being the factor	A COLOR OF THE PERSON NAMED IN	South and the second								

Franklin

7. Age (In yrs. last birthday)

Donald

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Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Frederick

Main

2. Date of Death Month

November

Day

2007

Frederick

4c. County of Death

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8. Date of Birth (Month, Day, Year Nov. 3, 19 9. Birthplace (State or Foreign Country) Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 Yes 2 No Frederick Frederick Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21702 1900 Rosemont Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes. specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iter 1 Yes 2 No If Yes, Give Year or Dates: XXXVever Married 2 Married 1 ☐ Yes 2 ☐ No Saltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farming Farm Hand/Laborer 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mamie Trail Roger L. Main 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5735 Bartonsville Road, Frederick, MD 21704 19a. Informant's Name/Relationship (Type. Print) Richard L. Main, Jr., nephew Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Important: If It any Injury or o XBurial 2 Cremation 3 Removal from State Mount Olivet Cemetery Nov. 8, 2007 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service License 22 Keeney and Basford PA Funeral Home 02 MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Organ System Failure **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 0065443 LARIMOVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELENA 400 West Seventh Street, Frederick, MD 21701 IarikovA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL

P.O. Box 68760, Records, Division or Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] []] 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Year **Physician** OCTOBER 23, 2007 2:00 A^M LAURETTE MILLER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Days Hours 1 ☐ M 2 🖫 F 84 NEW YORK 12/09/1922 089-20-1016 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND MONTGOMERY ROCKVILLE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 MONTROSE ROAD 20852 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL RECORDS LIBRARIAN HOSPITAL 17. Father's Name (First, Middle, Last) Be MATTHEW WHITTEN ISABEL FRIEDLANDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES MILLER - DAUGHTER 5020 CALIFORNIA CIRCLE #203, ROCKVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State t ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State KING DAVID MEML GDNS 10/25/2007 FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 23a. Part1. Endo the elsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND Approximate Interval Between Onset and Death Immediate Cause (Final acute muccardu resulting in death) Due to () as a consequence of): arte Hears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician /Medical Examiner

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23 or 28s-1 show any niury or other traumatic event, the Medical Examinar must be notified at one.

Baltimore, Maryland 21215-0036

Examine Physician/Medical ٥ Be Completed

sete has been signed by the attending physicien and pege 2 should be detached for use as the burial-transit Medical Certification; To within 24 hours efter deatl To the Funeral Director: completely filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ■ No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 □Ector				23d. Date of delivery Month Day Year
Part II. Other significant conditions con	ntributing to death but not res	sulting in the underly	ing caus	se given in Part I.	23e. Did tobacc	to use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
evaluat	san full	MINERY!	Son	nce per	24a. Was an autopsy performed	
25. Was case referred to medical examiner?	lospital:			Othor	eath Check only one	
1 ☐ Yes 2 ☑/No	fospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA	4 Nursing	Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes 2 No	28d. Describe how in	njury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fa	ctory, o	ffice	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examination and manner stated.	owiedge, death occu ation and/or investiga	rred at t ation, in	he time, date and place my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier			29c. Li	icense number	29d. I	Date signed (Month, Day, Year)
195 S. K	ha, No		n	np 374	64 Oc	toler 23,2007
30. Name and address of person who co	mpleted cause of death (Iter	m 23a) (Type, Print)				
Can Tive	mo 6121	montrow.	ed	Rockvill	e. WD	20852
31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature		1 11		-

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

OCT 2 4 2007

Hospital or Attending Physicien:

State Registrar Archana Gupta, M.D.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

24035 Three Notch Road, Hollywood, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month KALIYAH MARIE MATTHEWS October 31, 2007 4:59 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Funeral Months Days Hours 2 1 □ M 2 1 F 19 10/31/2007 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits 1 X Yes 2 □ No **Funeral Director** MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 Consett Place 21703 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ Specify. Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Jerome Matthews Sheree Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Consett Place Frederick, Maryland 21703 Sheree Johnson Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 11/2/2007 | Smithsburg, Maryland 22. Name and Address of Facility Keeney & Basford P.A. F.H. Ka M01176 106 East Church Street Frederick, MD 21701 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im rediate Cause (Final disease or condition resulting in death) Zweeks gestation 331grams Due to (or as a c insequence of): 2h/9min Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 2 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending investigation Injury 1 TYes 2 TNo 2 Accident

be executed P.O. Box 68760. Division or Vital Records,

burial-transit attending physician and as the nse signed by the a d be detached f page 2 s certificate has After this funeral To the Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Director

show

r 28a-f sh notified

7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be a

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me

Physician

/Medical **Examiner**

with

death

filed within 72 hours after

3altimore, Maryland 21215-0036

3 Suicide

4 Homicide

State

Medical

29a. Certifier (Check only one)	1 Certifying F 2 Medical Exa	aminer: On th	the best of my e basis of exam nanner stated.	knowledge, death occurred at the time, date and place, and due to the mination and/or investigation, in my opinion, death occurred at the time	ne cause(s) and manner as stated e, date and place, and due to the
29b. Signature and	title of certifier			29c, License number	29d Date signed (Month Day

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Miller

6 Could not be determined

D 35141

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, 400 W7 +L Street, Frederick, MD 21701 MD

and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year) NOV 0 7 2007

Jarrelea VC

Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Veryle Edward Nave 19. /Medical <u>October</u> 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS- Memorial Campus Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 209-20-5983-A 79 Director 08/29/1928 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location Show 10a. State r 28a-f show notified at 10d. Inside City Limits Director Bedford 1 ☐ Yes 2 ☑ No Bedford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be read injury or other traumatic event, the Medical Examiner must be read. 447 Centerville Road 15522 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Tire and Rubber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar R. Nave Tewell ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Nave/ Wife 447 Centerville Road, Bedford, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 10/24/2007 Centerville, PA 21. Signatury of Juneral Service Lic 22. Name and Address of Facility Adams Family Funeral Home, (alis 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Conde 232 mel /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine under cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last mon Due to for as a consequence of): Examine certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) the 9∏Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 : autopsy performed? death? 1 🔲 Yes certificate 1∐ Yes 2□ No 2DNo Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ Ne 1 🔲 Inpatient P 2 X ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After t Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

3

State 31. Date filed (Month, Day, Year)
Registrar 00 2 2 2007



100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D17565

October 22, 2007

Baltimore, Maryland 21215-0036

	Exa	min
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
		and i

		_ For	Plea	se Type or P State of				c. Ensure A Health and N			jible.	
		1 - State Registrar 1. Decedent's Nam	e (First Middle				rtificate of			Reg. No. 2	007	35815
Physicia /Medic		Phyllis Ph	nillips							Day Day 20	07 ^{Year}	3. Time of Death 09:35 PM M
Examin	er	14717 Ma	in Street	n, give street and numb	er)		4b. City, Town,	or Location of Death Cresaptown		4c. Coun	ty of Death gany	
Funeral Director		5. Social Security N 215-20-64	456	6. Sex 7.	Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da October		Coul	place (State or Foreign ntry) ryland
ryland how at	. 1	Usual Residence of 10a. State	10b. County		10c. C	ity, Town or Lo	ocation				T-	10d. Inside City Limits
the Ma 28a-f s	ectol	Maryland 10e. Street and Nur		egany		resaptow						1 KiYes 2 No
h with 23a or st be r	al Dir	roe. Street and Nu	1471	7 Main Street			10f. Zip Code 21502-			U.S.A.	f What Cou	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Marr 3 Widowed	•	12. Was Decede Armed Force ed 1 Yes 2 If Yes, Give Year or Date	s? X No			Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-	- 14. Ra	ace - Americack, White,	etc.
'2 hour natural ical Ex	ted b		15. Decedent	's Education	5.	16a. Dece	dent's Usual Occu	pation	- 1	16b. Kind of	wn	
d within 7 giene. er than "r the Med	Completed	Elementary/Seco		College (1-40	or 5+)	cook	DO NOT use retire	e during most of worked)	king	board o	of educa	tion
uld be file Mental Hyg Irked othe itic event,	To Be C	17. Father's Name William		Last)				18. Mother's Nam Edith Ad		Maiden Surna	ame)	
and 2 sho ealth and N n 27 Is ma ier trauma		19a. Informant's Na Gerald Ph		ip (Type. Print) husb	and		ng Address (Street 7 Main Street	t and Number or Rui	ral Route Numbe		n, State, Zip ryland	21502-
Pages 1 ment of Hi ant: If iter ury or oth		20a. Method of Disp 1 X Burial 2 I 4 □ Donation	☐ Cremation	3 ☐Removal from Sta	te	cemetery, crer	sition (Name of matory or other pla Aemorial Pa	ace)	Date ober 21, 2007	20c. Location	-	own, State aryland
permit. Depart Import any Inj		21. Signature of Fu	ineral Service L	Rure	4	22	Name and Address Durst Fund	ess of Facility eral Home, 57	Frost Ave.	, Frostbur	g, MD	21532
Physician /Medical		23a. P. 1. Enter the shock, or hea Immediate Cause (disease or condition resulting in death)	Final	complications that caus only one cause on each a. Due to (or	PD		er the mode of dyi	ing, such as cardiac	or respiratory ar	rest,	y	Approximate Interval Between Onset and Death
be executed ician and burial-transit	ical Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or that initiated events resulting in death) L	riying injury	b								
ine law requires mat the deam certificate the has been signed by the attending physionage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 27 9 Unknown	months?	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	al death 3 □	Ectopic pregnanc	ey			ate of delive	ery Day Year
igne de c	2	Ω	icant condition	ns contributing to death	but not res	ulting in the un	derlying cause giv	ven in Part I.	23e. Did to		ntribute to th	ne cause of death?
	Completed	25. Was case referr)							sy med? 2⊠No	prior to cor	psy findings available inpletion of cause of
nysicia nis cert direct	lo Be	examiner? 1 ☐ Yes 2001		Hospital: 1 ☐ inpa	tient 2	ER/Outpatient	3 DOA Oth	26. Place of Deatl ner: 4 ☐ Nursing Ho			her (Specifi	/)
ath. or: After the funeral		27. Manner of ath 1 Anatural 2 ☐ Accident	5 Pending investiga	ation	njury Day Year)	28b. Time of Injury	28c. Injur Wor M 1	ry at	28d. Describe h			,,
within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	28e. Place of I	njury - At ho etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rura	l Route Number,
in 24 hou he Funer pletely fill	Medical	29a. Certifier (Check only one)	Certifying	Physiclan: To the best xaminer: On the basis and manner	or examina	wledge, death tion and/or inv	occurred at the ti restigation, in my	me, date and place, opinion, death occur	and due to the c red at the time, c	cause(s) and material and place	anner as st	ated. the cause(s)
2/4	2	29b. Signature and the second	title of certifier)	10/19	107	29c. Licens	se number	2	29d. Date signe	1	Day, Year)
718-8		Huma C	SMOK	ho completed cause of	death (Item	HA	erint) Sted	204 Cu	mbe	rlanc	nb	1P 2 1505
State Registra		31. Date filed (Month	2 2 2 200	7 Feet e	Mar s Sigila	Loss	وري					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 20 200 Physician HENRY homas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EASTON MEMORIAL HOSPITAL albot 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex Sex 1 M 2 ☐ F **Funeral** 214-12-613 Usual Residence of Decedent Yrs. Nov. 6, 1922 Director Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 'natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Tes 2 □ No Queen Anneis 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1010 Neck 12. Was Decedent Ever in U.S.
Armed Forces?
1 Dres 2 No Werld
If Yes, Give War R
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Wan II Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contractor-(Excavation Construction Department of Health and Mental Hygic Important: If Item 27 Is marked other I any Injury or other traumatic event, <u>tt</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be Health and Mental Walter Pages 1 and 2 should <u>i na</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jones St. Centreville MD. 2/6/1
ition (Name of Date 2002 Accation - City or Town, State WilMer Joan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/27/07 Chester, MD. Chester Cemetery 10/27/07 CI 22. Name and Address of Facility Henry Funeral Home, P. A 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 23a. Part f. Enter the disease, or complications that caused the deads. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD.21613 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 30 min **Physician** /Medical Due to (or as a consequence of): Examiner Tens cause, Clisease or injury that initiated events resulting in death) Last Due to (or is consequence of) Examiner certificate be executed Pars ser and Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No Records, P.O. ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has 25. Was case referred to medical examiner? 2 No certificate or Vital To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ٩ this within 24 hours after death.

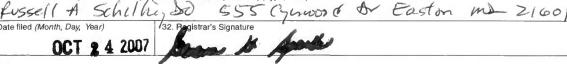
To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Matural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Russilla . Eluly

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of dighth (Item 23a) (Type, Print)

20



10-21-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** PM 5. ATHERINE /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F Months Days Hours Min. Director 70 30-MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? · 5. A KENNINGTON AVE. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Specify: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced ShiTE 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be E. SARRIAD 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANTER ATHERINE (MD. 21061 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 20b 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ROENT CREMATOR 4 ☐ Donation 5 ☐ Other (Specify) -07 21. Signature of Fundal 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 23 Part1. Enter the diseas or complete emiliaring shock, or heart fallure. List only one cause on Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a sequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi and Due to (or as a consequence of): attending physician Physician/Medical the l as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 mon Day 4☐Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 □Unknown 1 □ Yes 2 □ No page 2 should Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy perform death? 1 ☐ Yes 2 🗆 No Division or Vital 1∐ Yes 2 **P** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 1 ☐ Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director; After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and titlerof certifier 29d. Date signed (Month, Day, Year) D24170

State Registrar 30. Name and address of person who

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38 NEWTOW ST Bultimere MD 21201

eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle_Last) 2. Date of Death Month **Physician** Day. 13/1 0 24 ZUV /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 20 OSPITAL Baltimore AUTIMOR Social Security Number 7. Age (In yrs. last birthday) Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days Hours Min. 219-44-3503 62 Director 14 1945 Maryland April Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director W. Virginia Berkeley Falling Waters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1801 Vineyard Road 25419 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □ Yes Ž No Specify. ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irvin Dick Bessie Rachel Weaver ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Russell W. Robinson - husband 1801 Vineyard Road Falling Waters W. Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 Removal from State St. Paul's Cemetery 10-27-2007 Clear Spring Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Douglas A. Fiery Funeral Home Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NON NSULID MEDIE PR5 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of deliver in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not, resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐Unknown Completed 50 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed CORONIA 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 2 No Hospital: Other: မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 \Bursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death | Director: / 2 Accident 3☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I completely filled filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

15H-10

P.O. Box 68760,

Division or Vital Records,

State Registrar

31. Date filed (Month, Day, Year, OC

29b. Signature and title of certifier

7 51

29d Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

ALE BACTIMORE 20215

			For State	State	of Maryla		artment of		and Me	ental Hyg	jiene			
			Registrar 1. Decedent's Name (First, Middle	n I set)		Cei	tificate of	Death		2. Date of Dea	leg. No. 2	007	358	9
	Physici		, ,		T ₂₀₀					Month	Day	Year	C. Time of Death	,
	/Medic		Robert Eugene R 4a. Facility Name (If not institution				4b. City, Town,	or Location o		October		ty of Death	5:14 a M	_
	LXaIIIII	C!	Suburban Hospit				Bethesd	а			Monts	omery		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Yea Months Days	If Under 2	24 Hrs. 8 Min.	3. Date of Birth (Month, Day	`		lace (State or Foreig	n
	Director		215-44-5005	M ☐M 2☐F		60Yrs.	Months Days	Hours		Dec 13.		Mary		
Т	and w		Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Lo	cation					1	0d. Inside City Limits	
	f sho	ŏ											1 □ Yes 27 No	
	the N 28a-	Director	MD Montgo	mery	S1.	lver Sp	ring 10f. Zip Code				10g. Citizen o	f What Cour	try?	_
	3a or		2700 Barker Str	eet			20910				USA			
	be filed within 72 hours after death with the Maryland the Hylgiene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a on 28a-f show event, the Me-K-al Examiner must be notified at	Funeral	11. Marital Status		cedent Ever in	U.S. 13.	Was Decedent of	Hispanic Orig	gin? (Speci	ifv Yes or No-	14. R	ace - Americ		_
٥	after or ite mine		1 Never Married 2 Marr		2 No		fYes, specify Cu I∐Yes 2.5X1No			icari, etc.)		lack, White,		
215-0036	lours ural", I Exa	d b	3 ☐ Widowed 4 又 Divorced	Year or I							Sper	White		
<u>ν</u>	"nate	Completed	15. Deceden (Specify only highe	is Education st grade completed)	16a. Deced	lent's Usual Occi kind of work don OO NOT use retir	ipation a during most	t of working	9	16b. Kind of	Business/In	lustry	
7	within iene. than "u	ф	Elementary/Secondary (0-12)	College	(1-4or 5+)		ess Owne				Tandaa			
ם ס	filed Hygi Sther ent, tl		17. Father's Name (First, Middle,	Last)		Dustin	ess owne		er's Name (First, Middle,	<u>Landsc</u> Maiden Surn			\neg
land	buld be f Mental I arked of atic eve	To Be	Robert Eugene Ro	eynolds				Marga	ret F	ransan	nah Bl	ose		
Mary	i 2 should be filed vand Mental Hygie I is marked other traumatic event, th		19a. Informant's Name/Relations			I	g Address (Stree					n, State, Zip	Code)	
e, Z	and 2 ealth n 27 i		Tara Watkins/da	ıghter			Darnel	1 Dr.			0832			
ore	Jes 1 if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 【XICremation	3 □Removal from		Place of Dispo cemetery, crer	sition <i>(Name of</i> natory or other pl	ace)	Da	ite	20c. Locatio	n - City or To	wn, State	
	tant:		4 ☐ Donation 5 ☐ Other (S	pecify)	Cł		ce Crema				Beltsv			
baitimor	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service	Licensee	+-	GC	Name and Add	ess of Facility e Cre m	_{lation}	Servi	ce P.	O. Box	784	
	20240		230 Part 1 Enter the dimese or	N ever	MC MC	11251 Re	verly I	. Heck	rotte	P. A.	Clark	sville	MD 2102 Approximate	9
			23a. Part1. Enter the di wase, or shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.	/- co		ing, such as	cardiac or	respiratory arr	631,		Interval Between Onset and Death	
	Physician /Medical	Н	disease or condition resulting in death)	a. Due k	(or as a conse	aff 1	2)					_	14r	_
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conse								1	
	ocuted nd transi	Examiner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c/		remit							4cute.	
Š	e execian a	Ě	resulting in death) Last	Due to	(or as a conse	equence of):	Arter	110	ISPA	10				
09/90	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d	_07'07V	any	11876	7	7 (7 -	<i>-</i>				
×	certifi iding ise as	/Me	IF FEMALE:	23c. If yes, or	utcome pf preg	nancy					224	Date of delive	2004	
DOX	atter I for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live	birth 2 Fe	tal death 3	Ectopic pregnan Other (specify)	cy				Month	Day Year	
j.	t the or	Physician/Me	9 Unknown	9□Unkr	nown									
'n.	w requires that the death certific been signed by the attending p should be detached for use as	by P	Part II. Other significant condition	ns contributing to	death but not re	esulting in the ur	nderlying cause g	iven in Part I.	*	23e. Did to	bacco use co	ontribute to ti	ne cause of death?	
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ပ္သ	law r as be 2 sh	Completed								24a. Was a		b. Were auto	psy findings available	е
	The aate h	Con								perfor	med? 2 No	death?	2 □ No	
ק ב	cian: ertific ector,	Be (25. Was case referred to medical examiner?						of Death ((Check only or	ne)			
5	Phys this al dir	P	1 ☐ Yes 27 No 27. Manner of Seath		Inpatient 2	ZER/Outpatien 28b. Time of	1 3 DOA			e 5 Resid			y)	_
	ding h. After fune	tion	1 Natural 5 Pendin 2 Accident investig	g (Moi	nth, Day Year)	Injury	W	ork? ∐Yes 2 ∐ l		od. Describe II	ow injury occ	urieu		
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5	al or s after od in t	Certification:	4 ☐ Homicide determ	build	ding, etc. (Spec	ony)				City or Tow	n, State)			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or		29a. Certifier 1 Certifyin	g Physician: To th	ne best of my kr	nowledge, death	occurred at the	time, date an	nd place, ar	nd due to the o	cause(s) end	manner as s	tated.	\neg
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	vit To	<	29b. Signature and title of certification	111			_	ise number スリノチム			29d. Date sig		* '	
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3)	43		30. Name and address of person	who completed cau	ise of death (Ite	em 23a) (Type,	00 0/0	l lon	not h	WWW /2	Ed A	others	007 la, Md 208	1/1
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sigi			000	7-10	,,,,,	- 10	-/-//-	afrill 200	1
	Registr	ar I	OCT 2 !	5 ZHH7 /	No.	L								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 35820 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Margaret Shumaker 11 01 07 1545 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WMHS-Braddock CAmpus Cumberland **Allegany** 8. Date of Birth (Month, Day, Year) Sep 15, 1940 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1□M 2□F Months Davs Hours Country) MD Director 212-38-6431 Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Cumberland MD Allegany 1√ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 411 Grand Avenue Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 □ Xo Baltimore, Maryland 21215-0036 "natural", or Specify: Specify: þ white 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Martin's Food Market cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If item 27 is marked of any injury or other. ould be f Mental I Catherine Knippenberg Norris Maurice Norris ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Cumherland MD 21502 19a. Informant's Name/Relationship (Type. Print) husband Vincent Shumaker 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ *Burial 2 ☐ Cremation 3 ☐ Removal from State 11/5/2007 Flintstone MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Fart1 Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BREAST CANCER **Physician** 1ETASTATIC nente /Medical Due to (or as a consequence of): **Examiner** ULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner PLEURAC METASTAS and Due to (or as a consequence of): physician a Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 **N**O 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 4 ☐ Nursing Home ၉ 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident (Month, Day Year) Injury 5 Pending Io un.
within 24 hours after v.c...
To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/200

State

E 921 SETON DRIVE CUMBERCAND, MD. 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

				partment of Health and Mental Hygiene						
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death Reg. No 2007 35821						
	Physici /Medi		Phyllis Smith	2. Date of Death Month Day Year 10 20 07 10:35 P M						
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death						
			Apex Health Of Silver Spring 5. Social Security Number 6. Sex 7. Age (In yrs. last birthol.	Silver Spring Montgomery County 1) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9, Birthplace (State or Foreign						
в	Funeral Director	П	231–34–6776 1□ M 2X F 74 Yrs	Months Days Hours Min (Month Day Year) Country						
9	PL ,		Usual Residence of Decedent							
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	the M 28a-f lotifie	Director	DC N/A Washin							
	with Ba or t be r	ij	4625 17th St., NW	10f. Zip Code 10g. Citizen of What Country?						
	death ms 2;	Funeral		20011 US 3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.						
9	after or ite mine	/ Fu	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give	- The second of the second of						
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notifled at	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	Spoonly. Black						
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212	y with giene. r thar the N	E O	Elementary/Secondary (0-12) College (1-4or 5+)	Opportunity Specialist Federal Government						
b	be filed tal Hygid d other event, the	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)						
Sla	2 should be and Menta is marked aumatic ev	P P	William Howard Hubbard	Pearline Carter						
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If flem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at			illing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
	1 and 2 Health em 27 i		Howard S. Smith / Son 462. 20a. Method of Disposition 20b. Place of Dis							
altimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		123 Dana 2 Dolemation 3 Differnoval from State	rematory or other place)						
Ħ	mit. F partme ortan Injur		4 □ Donation 5 □ Other (Specify) Rock Cr 21. Signature of Fymeral Sergice Licensee	eek 10/25/07 Washington, DC 22. Name and Address of Facility McGuire Funeral Service, Inc.						
m	Depar Impor any Ir		Undre Thompson	7400 Georgia Ave., NW Washington, DC 20012						
Г			23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.							
	Physician		Immediate Cause (Final disease or condition a. A THERO SCLER	OTIC CARDIOVASCULAR DISEASE UNKNOWN						
	/Medical Examiner		resulting in death) Due to (or as a consequence of):							
		e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):							
2	tuted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ŏ,	e exec an an rrial-tr	Exa	resulting in death) Last Due to (or as a consequence of):							
8760,	cate be executed physician and the burial-transit	dical	d							
တ	certific ding p	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy							
B	eath catternate for us	Completed by Physician/Me	in the past 12 months?	□ Ectopic pregnancy 23d. Date of delivery □ Other (specify) Month Day Year						
Vital Records, P.O. Box	t the c by the ached	hysi	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown							
S,	es tha gned l	oy P	Part II. Other significant conditions contributing to death but not resulting in the							
ord	equire	ted	Cenchrovascular accident ; a Tracheostomy, G-tube for	1 Yes 2 No 3 Probably 4 Unknown						
Š	e law i	nple	Tracheustomy, G-tube tu	autopsy prior to completion of cause of						
<u>=</u>	i: The			performed? death? 1□ Yes 2 No 1 □ Yes 2 □ No						
₹	siciar certif irecto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ EB/Outpatient	26. Place of Death (Check only one)						
0	g Phy er this eral d	<u>ان</u>	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d. Describe how injury occurred						
ion	ath. or: Aft	atio	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 □ Yes 2 □ No						
Division or	or Atterde	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	pital curs af eral D		Continue Description Table							
	24 hos 24 hos Fun etely t	Medical	29a. Certifier (Check only one) 1	ath occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)						
			Chowdly, mp	043121 10/21/07						
	10		30. Name and address of person who completed cause of death (Item 23a) (Type	Drint)						
			NURUL CHOWDHURY, MD; 15216 31. Date filed (Month, Day, Year) 32. registrar's Signature	DINO DRIVE & BURYONS VILLE, MD 20866						
	Sta Registra	٠.	ST. Date lieu (Month, Day, rear) Stategistrar's Signature	conti						
			Market Jan	(49 PH						

			1- For State Of Maryland		tificate of L		,,,	ene g. No. O O O T	. 05000
	78 ax		1. Decedent's Name (First, Middle, Last)				2. Date of Death	200	3. Time of Beatin
	Physici /Medio		Deborah Laughlin Shaull				October	24, 2007	5:15 a ^M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
		3	Dove House		Westmins	ter		Carroll	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign
	Director		216-50-2855 60	Yrs.			Dec 8, 1	1946 Mar	yland
	and t		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Loc	ation				10d. Inside City Limits
	Mary f sho ied a	ro	MD Howard Ellic						1 ☐Yes 2 No
	r 28a	irec	10e. Street and Number	OLL C	10f. Zip Code		10	g. Citizen of What Co	ountry?
	3a ol	i D	3363 N. Chatham Rd. #K		21042		US		
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	/as Decedent of His Yes, specify Cubar	spanic Origin? (Sp		14. Race - Ame	
9	after or ite mine	/Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 No If Yes, Give		Yes, specify Cubai	n, mexican, Puerto Specify:	Hican, etc.)	Black, Whit	e, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 23a-f show ent, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 Ma Divorced Year or Dates:			эреспу.		Specify: Wh	ite
7	"natı	Completed	15. Decedent's Education 1 (Specify only highest grade completed)	6a. Decede	ent's Usual Occupa kind of work done d O NOT use retired)	ition uring most of work	ing 1	6b. Kind of Business	/Industry
7	withii ene. than be M	ошо	Elementary/Secondary (0-12) College (1-4or 5+) 1 Δ	rtist.				Commercial	Art.
9	filed Hygi Sther ent, t	ပို	17. Father's Name (First, Middle, Last)	TCTSE		18. Mother's Name			ALC
au	ld be lental ked d ic ev	To Be	John Randall Shaull			Mary Rebe		,	
Maryland	2 should be i and Mental I is marked of raumatic eve		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing				City or Town, State, J	Zip Code)
	1 and 2 Health a em 27 is		Meredith Rachel Leary/daughter 7	026 D	eerfield	Rd Pikes	ville, M	D 21208	. ,
altimore,	es 1 a of He of He fitem		20a. Method of Disposition 20b. Place cerms	e of Dispos	ition (Name of atory or other place	, (Date 2	0c. Location - City or	Town, State
Ĕ	Pages ment of I ant: If its ury or o				e Cremato		/07 Be	ltsville,	MD
ä	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show mimortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22. G-0	Name and Address	s of Facility	n Servic	e P.O. B	78/
10	205 # 9		Bevery I Halle MO12	51 Re	verly I.	Heckrott	P. P. A.	Clarkewil'	le. MD 21029
l,			23a. Part1. Enter the disease, or complications that caused the death. C shock, or heart failure. List only one cause of the line.	o not ente	r the mode of dying	, such as cardiac o	or respiratory arres	st,	Approximate Interval Between
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	uted Insit	ш i	Sequentially list conditions, if any, leading to fining diate cause. Enter Underlying Cause (Disease or injury that initiated events	20 0.7.					
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68760,	rificate be executed ig physician and as the burial-transit	ledical	d						
99	ng ph as th		IF FEMALE.						
ROX	death ce e attendir d for use	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 mop ths? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dec	ath 3□E	Ectopic pregnancy			23d. Date of del	
oj.	w requires that the death cer been signed by the attendin should be detached for use	Physician/	1 Yes 2 No 4 Pregnant at time of death		Other (specify)			Month	Day Year
_	hat the		Part II. Other significant conditions contributing to death but not resulting	n in the unc	derlying cause give	o in Port I	230 Did tobo	acco use contribute to	. M. a. a. a. a. a. d. a. a. M. O.
Hecords,	The law requires that the te has been signed by the sage 2 should be detache	ğ	and the state of t	y iii tilo qiit	ionying cause give	Till Carti.	1 ☐ Yes	/	•
Ö	v requ	Completed			-				
ě	ET SO OI	du.					24a. Was an autopsy perform	prior to o	topsy findings available completion of cause of
_	Ø ₽ 1	ပ္ပ	25. Was case referred to medical				1□ Yes 2	No 1 ☐ Yes	1
	ding Physician: The After this certific funeral director,	o B	examiner?	Outpatient	Other	26. Place of Death			Hospice
	ding Phys	⊢ ⊦	27. Manper of Death 28a. Date of Injury 28t	o. Time of	28c. Injury	at 2	28d. Describe how	ce 6 Other (Specification)	orty)
sion	Attending r death. ector: After by the funer	atio	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	Work? M 1 □ Y	es 2□No			
	ir Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, stree	et, factory, office	2	28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
2	iltal o Ins aff ral D								
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) Medical Examiner on the basis of examination and manner stated	lge, death o and/or inve	occurred at the time estigation, in my op	e, date and place, a inion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	ithin 2	Med	29b. Signature and title of certifier		29c. License				
	F ≥ F 8) / MO			7		d. Date signed (Mont	
	100	}	30. Name and address of person who completed cause of death (Item 23a	a) (Type P	rint)			10/ 69/	2007
C	74		WOUSE GAFFM N	2 1	TTS Cer	the spece	t. alsw	ninte 1	02/15)
	Stat	е	31. Date filed (Month Day, Year) 32. Registrar's Signature				1	1/1	
	Registra	ır	OCT 2 5 2007 Marie 2	X A	sast s				

					Indelible ink. Ensure			
			1 _ For State	_	epartment of Health and	Mental Hygie	ene 007	35823
			Registrar		Certificate of Death		j. No.	
Н	Physici	an	Decedent's Name (First, Middle, La	st) ~ /(- i 1	00-	2. Date of Death Month	Day Year	3. Time of Death
	/Medio		Daisy	EliZabeth	Sampson	Oct. 1	72007	10:55 A M
	Examir	er	4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Dea	th	4c. County of Deati	2
			Mallard Bo	ly Nursing Hom		9 6 8. Date of Birth	Dorch	
	Funeral Director		5. Social Security Number 6. S	7. Age (lalyrs. last birth	Months Days Hours Min	(Month, Day, Y	(ear) Co	hplace (State or Foreign untry)
			Usual Residence of Decedent	0 3		June 1,	1922 Ma	aryland
	Maryland -f ehow		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
Ω	Mar	햦	MD Dorce	hester Ca	Mbridge			1 ☑ Yes 2 ☐ No
Z	with the a or 28s	ie e	10e. Street and Number		10f. Zip Colie	100	g. Citizen of What Co	untry?
3	th wi	Funeral Director	502- Cliv	iton Stree	+ 2/6/3		U.S.A	
0	eep	I Per	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (\$\) If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White	
36	or if	Y.	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 12 No If Yes, Give	1 ☐ Yes 212 No Specify:		Specify:	
5-0036	72 hours after deeth naturai', or iteme 23 Jical Examinar mus	Completed by		Year or Dates:	Decedent's Usual Occupation	16	Bb. Kind of Business/	CK
15	n 72	jete	15. Decedent's E (Specify only highest gra	ade completed) (Give kind of work done during most of wo life. DO NOT use retired)	orking	b. Kind of business/i	moustry
2121	filed within Hyglene. Sther than "	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	eamstress	C	elling f	actory
	Hygi other	Be	17. Father's Name (First, Middle, Last,			me (First, Middle, Ma	aiden Sumanue)	101/
lan	ould be I Mental narked o	ToB	Poto McCY	ready	Sara	h /.	Johnson	10
Maryland	\$ 5 E E	-	19a. Informant's Name/Relationship (Mailing Address (Street and Number or R	lural Route Number, (City or Town, State, Z	ip Code)
	1 and 2 Heelth a em 27 is		10+15 Ja	hnson 50	2 Minton Street	+ Cambi	idae. M	D.21613
Baltimore,	es 1 a of He fitem r othe		20a. Method of Disposition	20b. Place of I	Disposition (Name of crematory or other place)	Date 20	oc. Location City or	Town, State
E	Pages nent of int: If it		1 Marial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	JRemoval from State	4 1/1	124/07 E	. N. Mark	et. MD.
alti	permit. Page Depertment of Important: If eny injury or once.		21. Signature of Funeral Service Licer	1see	22. Name and Address of Facility			
8	89 E 2 8		Janelle	C. Steures	HENRY FUNERAL 1	tome, P. A.	abridar.	MD.2/613
			23a. Part / Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not one cause on each line.	HEWRY FUNERAL I HEWRY FUNERAL I S 10 WASHING TOA at enter the mode of dying, such as cardia	ic or respiratory arres	, 37	Approximate Interval Between
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				Due to (or as a consequence of):		l	/
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, P.O. Box 68760,		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 W No 9 Unknown	b. UVO SCOSIS Due to (or as a consequence of Due to (or as a consequence of d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death): 3 □ Ectopic pregnancy 5 □ Other (specify)	23e. Did toba		Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2007 35824 State of Maryland / Department of Health and Mental Hygiene Pedro Vasquez Vail 1- For State Certificate of Death Rea. No Registrar 3. Time of Death 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day October 28, 2007 0803 hrs Vasquez Vail **Medical Examiner** Pedro 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Hyattsville, MD Prince George's 8210 Tahona Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours \mathbf{x}_{M} 23 2/19/1984 Guatemala none Director 2 Usual Residence of Deceden 10d. Inside City Limits 10c City Town or Location 10a State Hyattsville George MD Prince 1 Yes 2 X No and 2 should be filed within 72 hours after death with the Maryland Director 23a or 28a-f s notified at on 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20783 Guatemala 1418 Kanawha Street #201 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No White Yes Guatemalan If Yes, Give Year 1 X Yes 2 No specify: Specify 3 Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Handyman 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Cruza If item 27 is marked Guillermo Vasquez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1418 Kanawha St #201 Hyattsville, Md20783 Aroldo Vasquez Vail/Brother 20c. Location - City or Jown, State Quetzaltenango, 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 X Burial 2 crematory or other place) Cremation 3 X Removal from State 듷 Guatemala 11/07/2007 Centro Cajola Cem Donation 5 Other Spe-21. Signatur of Fureral Service BHTLTPddcs. RTWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Between Onset and /Medical Death Ethanol intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED ^{AMENDED}27,28a-f, permE,g873m 11/8/07 TT attending physician or use as the burial -23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy icate has bage 2 sh performed? death? ✓ Yes 2 No 1 V Yes certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical of Vital Be Hospital: Other: Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27 Manner of Death Certification: Natural Yes 2 X No unk Division Pending Fnd 10/28/2007 Fnd 7:54 am the Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide 8210 Tahona Dr. Hyattsville, MD To the Hospital or within 24 hours af To the Funeral D determined (Specify) Park/Recreational area Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 28, 2007 O.C.M.E. (linds 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

State

Registrar

Ana Rubio MD.

31. Date filed (NOT) Pa

Assistant Medical Examiner

2007

Registrar's Signature

Amen	ded #23	a (c), nls, Please Type or Print in					
per	phy., 1	0/:	31/07, Allegany Co. State of Maryla.	nd / Depa	artment of Health and I <i>rtificate of Death</i>			35825
			State Registrar 1. Decedent's Name (First, Middle, Last)		Timeate of Beatif	2. Date of Death	g. Nof- U U I	3. Time of Death
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	Examir		4a. Facility Name (If not institution, give street and number) Washington Crunt Hospita	1	4b. City, Town, or Location of Death	. ^	4c. County of Death	,
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Nonth, Day,	9. Birth	place (State or Foreign
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Maryland	should be and Mental smarked o	은	Fred Winehrend 19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Number or R			
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	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier (Check only (C	nowledge, deat nation and/or ir	th occurred at the time, date and place nvestigation, in my opinion, death occ	e, and due to the ca curred at the time, d	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	ithin 2	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. License number	25	9d. Date signed (Mont	h, Day, Year)
	VA-1		»/ <u>\</u>	· P	D21457		10-26 3	2
	nus		30. Name and address of person who completed cause of death (It	em 23a) (Type,	Print) 2-821 - OAK 14)((M/G	HACER	STOWN, MO
	Sta	ite	31. Date filed (Month, Day, Year) 32 Tegistrar's Sig			1.1 // 1/2	- (1)/-	-(0
	Regist	rar	OCT 3 1 2007	B. Ca	SALL S			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] []] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 6:17 a M 30, 2007 October 0 Donald J. Wojnar, Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/15/1957 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 11XM 2□F New York 50 055-54-3422 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Great Mills St. Mary's Maryland| 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 22112 Towey Court 20634 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3K Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior Test Engineer Defense Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Donald J. Wojnar, Sr. Mary Anne Krause 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22112 Towey Court, Great Mills, Maryland Donald J. Wojnar, III/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipense 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Gr M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Yorkedis Infination Sec Due to (or as a consequence of): Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of)

Physician /Medical Examiner

Examiner

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Completed

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Certification: To

Medical

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after death with and Mental Hygiene.

is marked other than "natural", or Items 23a or.

Pages 1 and 2 s nent of Health an Department of Health Important: If item 27 any Injury or other tr

Baltimore, Maryland 21215-0036

burial-trar physician the signed k funeral l or Attend after death Director:

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 ☐ Suicide

4 Homicide

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

9∏Unknown

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 XÚnknown

24a. Was an autopsy performed: 1∐ Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2□No 1 ☐ Yes

Year

25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 1 Inpatient 2 X ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

ess of person who completed cause of death (Item 23a) (Type, Print)

Rd. Leonardtown. Maryland 201050 NOV 0 1 2007

State Registrar

within 24 hours a To the Funeral L the Hospital

		_ For		State	of Maryla	and / Dep	artment of I	Health an	id Mei	ntal Hyg	iene				
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/Medic			JAMES		· · · · · ·	W	NEBRENNE			10	22	07	0405	М	
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shou ind M imari	-	19a. Informant's Name/Rela		ype. Print)		19b. Mail	ing Address (Street	and Number o	or Rural R	oute Numbe	r, City or T	own, State,	Zip Code)		
and 2 alth a 27 is		Nancy Winebre	nner	wi	fe	150 1	Main Street	(Grants	ville	M	aryland	21563-	•	
of He fitter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremat	ion 2 🗆	Domoval from		 Place of Disp cemetery, cre 	osition (Name of ematory or other pla	ice)	Date	•	20c. Loca	tion - City or	Town, State		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Insperatment of Heatth and Mental Hygiene. Insperatment of Heatth and Mental Hygiene. and proportant: If them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Ser	vice Licen	sea	_		22. Name and Addre		67 F-	-4 A	Can othe	was MD	21522		
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Physician /Medical		disease or condition resulting in death)	-	a	2745	SIAIIC	- KENF	+2 66		CHK	CIN	ודייט	Moule	~7-	
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s afte	Certification:	4 Homicide		Dulid	ling, etc. (Spe	ecity)				City or Tow	n, State)				
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	one) 29b. Signature and title of ce		and mar	ner stated.		29c. Licens								
		255. Signature and title bi ce	MICI	6	nal								th, Day, Year)		
5		30. Name and address of pe	rson who o	completed ac-	so of death /	Itom 22a) /Tur-	Print)	1) [[00	24	2001		
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Sta	te	31. Date filed (Month, Day,		32	Registrar's Si	gnature	-1 100/4		0.71	J = 1 = 1 C		11110	VI JU	-	
Registr	ar	OCT 2	3 200	M T	and the	J. A.	MASA.								

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT 2 9 2007

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32. Registrar's Signature

Registrar

State

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month CALVIN ZICAFOOSE Nov.2,2007 11:05am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 416 Mill Lane Cecil Earleville If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Peb 12 1936 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1XM 2□ F West Virginia 71 Feb 223-44-3784 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any ilury or other traumatic events. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Cecil Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 416 Mill Lane 21919 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XYes 2 No 1954
If Yes, Give
Year or Dates: -1956 1 Never Married 2 Married 1 ☐ Yes 2XNo Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer of Defense 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Christopher Zicafoose Dorothy Leila Cumby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig Zacafoose (son) 416 Mill Lane Earleville, MD. 21919 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State Kent Cremation 11/3/07 Smyrna, DE. 4 Donation 5 Dother (Specify) of Funeral Service Licensee Galena Funeral 118 West Cross Home of Step St. Galena, Stephen L. Schaech 21635 M00510 Part1 Int if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, box, or leart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ancveatio disease or ondition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page certificate 1∐ Yes 2 🗆 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \sum Nursing Home မ 1 Inpatient 2 ER/Outpatient 3 DOA 5☐ Residence 6 ☐ Other (Specify) this eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15+1 Barbara A. Parey / M.D. 111 W. High St. Elkton, MD. 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6-200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner OWSON If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year) **Funeral** Days Months 1 XM 2 □ F 060-44-9305 Yrs Nest Indies :25 AM Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County 28a-f show 1 ☐ es 2 ☐ No must be notified Director 1 timore 10g. Citizen of What Country? 10e. Street and Number 23a or Funeral Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 7 Married or. 2**□**No 1 🗌 Yes Baltimore, Maryland 21215-0036 ğ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than "natur the Medical I 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiene Important: If Item 27 is marked other tha any injury or other traumatic event, the 1 one. the 18. Mother's Name (First, Middle, Maiden Surnar Be ၉ 19b. Mailing Address (Street and Numb 20c. Location - City or Town, State a. Method of Disposition 1 ☐ Burial 2 ☐ 3 □Removal from State nation 5 Other (Specify) 21. Signature of Funeral Service Licenses altimore National MD 21729 Approximate Interval Between Onset and Death MEARS caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Title to for as a consequence off in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) I□Yes 2□No Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 26. Place of Death (Check onle one 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOS FICE 2010 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 1 ☐ Yes Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 1 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide within 24 hours a To the Funeral L Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D64395 6,2007 address of person who completed cause of death (Item 23a) (Type, Print) 9 RICHN, MO DOBE 6565 N CHAPLES ST, SUITE DANIEUE 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State 2007 NOV 0 Registrar

07-08453 Jef

ffrey Arnold		State of Maryla						7 0500			
		1- For State Registrar	Certifi	icate of Dea	th		g. No. 200				
Physicia edical Exami		Decedent's Name (First, Middle,Last) JEFFREY		RNOLD		2. Date of Deat Month October 3	Day Year 1, 2007	3. Time of Death 0320 hrs			
		4a. Facility Name (if not institution, give street and nu 4221 58th Avenue	mber)	1 .	, Town, or Location erdale		4c. County of Death Prince George				
Funeral Director		579-84-0073 Male 1x Male	7. Age (In yrs. last t	birthday) If Ur Mor Yrs.		er 24Hrs. 8. Date of Birds Min. 05/12/	th(MM/DD/YYYY) 9. Birt 1965 Foreig Cou	pplace (State or Wash, DC intry)			
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	Usual Residence of Decedent 10a. State MD 10b. County Prince Georges 10e. Street and Number	10c. City, To Capit	10f. Z	ip Code	10	Dg. Citizen of What Cour	10d. Inside City Limits 1 X Yes 2 No			
ith the M 23a or 2		12 Vale Place 11. Marital Status 12. Was Dec	edent Ever in U.S.		0743	gin? (Specify Yes or No	USA	one Indian Block			
	by Funeral	1 Never Married 2 X Married 1 Armed Fo 1 Yes 1 Y	orces? 2 X No	If Yes, spe	cify Cuban, Mexicar 2 No specify	n, Puerto Rican, etc.)	White, etc. Specify: Blac	k			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Completed	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) 12th College (1		during most of v	al Occupation (Give rorking life. DO NOT		Private	ndustry			
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	7. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Marie Carter									
MD 2 Id 2 should lith and M n 27 is m aumatic c	To	19a. Informant's Name/Relationship (Type, Print) Cassandra Wimbush Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 12 Vale Place Capitol Heights, MD 2074									
Baltimore, MD bermit. Pages I and 2 sho Department of Health and Important: If item 27 is njury or other traumati		20a. Method of Disposition 1 X Bunal 2 Cremation 3 Removal fra 4 Donation 5 Other Specify:	om State 20b. Place Cren	ce of Disposition (New Matery or other place of Disposition (New York Control of Control	ame of cemetery, ce) emetery	11/10/2007	Washington				
Balt permit Depart Impor		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bianchi 814 Upshur St NW Wash, DC 2001									
Physician Medical aminer		that the same of t	nshot Wounds		e of dying, such as	cardiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death			
	-	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	E	23b. Was decedent pregnant in the past 12 months?	ant at time of death	2 Fetal dea		ic pregnancy	23d. Date of delivery	Day Year			
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Records The law requicate has beer page 2 should	24a. Was an autopsy prior to complete the performed? 1 ✓ Yes 2 No 1 ✓ Yes										
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on of Vital tending Physician: ath. or: After this certifi the funeral director,	ıtion: To	27. Manner of Death 1 Natural 5 Pending 28a. Date Oct 31,	of Injury 28	8b. Time of Injury 318 hrs	28c. Injury at Wor	k? 28d. Describe Subject sho	how injury occurred	. Scene			
Division To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the	Certification:	4 V Homicide determined (Specify)	e of Injury - At home Other (specif		ory, office building, e	or Town, S	Street and Number or Ru State) e, Capitol Heights, ME	, · ·			
To the Hos within 24 h To the Fm	Medical	29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis and manner s	of examination and/								
E » F »	Me	29b. Signature and title of certifier			29c. License numbe		29d. Date signed (Mo				
5		30. Name and address of person who completed cluster Zabiullah Ali, M.D. Assistant Medic	al Examiner	111 Penn Str	eet, Baltimore,	MD 21201	200001 01, 200				
St Regist		31. Date filed (Month, Day, Year)	gistrar's Signature	Sperke	,		ME				

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and M	Mental Hygiene
Certificate of Death	Reg. No.
lame (First, Middle, Last)	2. Date of Death Month Day

			1 - State Registrar			Cei	rtificate	e of i	Death			Reg. No.		
ī	Dhuciai		1. Decedent's Name (First, Middle,	Last)			Month Day Year					3. Time of Death		
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	Examin	ner	4a. Facility Name (If not institution, Saint Josep		Cen	ter	4b. City,	Town, o	Location (of Death	חכ	4c. Co	unty of Death Bal	cimore
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	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
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	h with		1210 Meredith'	s Ford Road					2128	86		USA		
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0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced)		1□Yes 2		Specify:		,,		anihu	White
ה	72 h "natu	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced (Give	dent's Usua kind of wor DO NOT us	l Occup k done	ation during mos	st of workir	ng	1	of Business/Ir	•
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Ä	and 2 salth a 27 is		Richard C. Banta	/Husband		1210	Mered	lith	's Fo	rd Ro	d. Tow	son, Ma	aryland	1 21286
<u> </u>	of Her		20a. Method of Disposition 1 ☐ Burial 2XXCremation	3 □ Removal from State	20b. PI	lace of Dispo emetery, crei	sition (Nam natory or ot	ne of ther plac	e)	D	ate	20c. Locat	ion - City or T	own, State
altillion altillion	Pag ment tant: I		4 □ Donation 5 □ Other (Sp		Hil	1top 9							n, Mary	
סמ	Depart Import any In		21. Signature of Funeral Service L	Mul			2. Name and			1101			neral H d 21204	lome, Inc.
			23a. Part1. Enter the disease, or shock, or heart failure. List of	implications that caused to ally one cause on each line	he death	. Do not ent	er the mode	e of dyin	g, such as	cardiac o	respiratory	arrest,		Approximate Interval Between
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	ted sit	Examiner	Sequentially list conditions, it my leading to in reclate cause. Enter Underlying Cause (Disease or injury	Total to for as a	consequ	terice on:								
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O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal	death 3	Ectopic pre Other (spe		′			23d	I. Date of deliv Month	ery Day Year
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	70		30. Name and address of person w	ho completed cause of dea	ath (Item	23a) (Type,	Print)			141-141-14				
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	Sta Registr			32. Registrar	edit is	St 1	TOBALL.	A. S. C. C. C. C. C. C. C. C. C. C. C. C. C.						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 🚄 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 11:24PM Physician 05 BURKETT GLORIA 07 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORE GOOD SAMARITAN HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5 Social Security Number Months Days Hours **Funeral** 1 □ M 2 💢 3/3/1931 Maryland 76 216-28-5612 Director Usual Residence of Decedent 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No Baltimore MD Baltimore 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examiner must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 6 Skylark Ct. Apt. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Mail sorter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Porter Douglas Leon Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4015 Highland Avenue, Baltimore, Maryland 21225 Pages 1 and 2 ment of Health a ant: If item 27 is jury or other train Beverly Cantrell / Dauq. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If i any Injury or Loudon Park Cemetery 11/9/2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signatur of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final septic Shock **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner metabolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): physician a Physician/Medical as attending 23d Date of delivery nse (23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant Year 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? ίο 5 ☐ Other (specify) ☐Yes 2☐Mo ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 1 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 1 Mpatient Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of funeral 27. Manner of Death ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. within 24 hor To the Fune completely fi To the

> State Registrar

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Bharret Kaun

NOV 0 8 2007

GOOD SAMARITAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL \$2. Registrar's Signature

Medical

29c. License number

RESOOD

5601 LOCH RAVEN BLVD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

35834 State of Maryland / Department of Health and Mental Hygiene? [] []] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Year Mirjam **Physician** 1.40pM 07 31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Retirement Community Catonsville Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Director 094.01.0256 Feb 4, 1919 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 27 is marked other then "natural", or Iteme 23a or 28e-f show traumatic event, the Medical Examinar mount be notified at 1 ☐ Yes ŽŽNo Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA Completed by Funeral 719 MATDENCHOICE LANE 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Y Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√√ No Specify: 3xxWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Archdiocese of MD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked c Mental ဥ Joseph A. Jaeger Julia Monaghan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a important: if item 27 is any injury or other traisons. 20925 Marineview Dr SW, Seattle, Washington 98166 Ed Murphy Spr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory Nov 6, 2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility Fink Funeral Home, P.A. Gregory Vink 426 Crain Hwy S, Glen Burnie, ND 21061 MOTTER 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, behave failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) ete hes been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed this certificete 2□ No 1 Yes 2 No 1 ☐ Yes the Hospital or Attending Physicien: After this certification funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification; To 1 ☐ Yes 2 ☑ 📉 🗸 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannerol Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by within 24 hours after of To the Funerel Direct completely filled in by 4 | Homicide 29a. Certifier TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D44377 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 711 Maiden
32 Registrar's Signafure Choice Lane, Catonsville, mp 21228

DHMH 17 Rev 1/2001

State Registrar

31. Date liled (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Wilfried Walther Cook State of Maryland / Department of Health and Mental Hygiene 2007 35835 1- For State Certificate of Death Reg. No. Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day November 2, 2007 **Medical Examiner** 1623 hrs Wilfried W. Cook 4a. Facility Name (if not institution, give street and number) c. County of Death b. City. Town, or Location of Death 7928 Bridge Avenue Rosedale **Baltimore County** 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) Months Davs Hours Director Country)Germany 218-54-4323 07/21/1951 1 XM 2 F 56 Yrs Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show notified at once. Yes 2 X No MD Baltimore Rosedale hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7928 Bridge Ave 21237 USA Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-, or items Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1X Never Married Yes Yes 2X No specify: Widowed 4 Divorced If Yes, Give Year Specify: White the Medical Examiner þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Internet Business Computer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) . Pages I and 2 should be filed ment of Health and Mental Hy, tant; If item 27 is marked of or other traumatic event, this David A. Cook, Sr. Bertha Fischer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Cook Sr. Father 1316 Pine Grove Ave. Rosedale MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State timore, crematory or other place) 1X Burial 2 Cremation 3 Removal from State BelAir Memorial 11/7/07 BelAir, MD Donation 5 Other Specify 9 22. Name and Address of Facility Cvach/Rosedale Funeral 21. Signature of Funeral Service Licensee Home 1211 Chesaco Ave Rosedale MD 21237 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and hvsician/Medical X UNPENDED attending physician of for use as the burial -AMENDED #23a.PII.27.perME.g873. 11/14/07 TT Box 68760. IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown by the grand f Unknown P.O. 畐 Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ Diabetes mellitus Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has . death? performed? page ✓ Yes 2 No 1 🗸 Yes 2 ospital or Attending Physician: hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) of Vital æ Hospital: 4 Other 4 Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene this 1 ✓ Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Division Yes 2 neral Director: Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined (Specify) To the Funeral Homicide 29a. Certifier 1 cal Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 3, 2007 erson who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

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31. Date filed (Month, Day, Year,

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111 Penn Street, Baltimore, MD 21201

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1) ICKI COX November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Randalls Town NorthWEST HOSPITAL Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month Day Year) 3-12-1960 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 👿 F 47 MD 220-80-7056 Director Usual Residence of Decedent 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-1 show ury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10d. Inside Cify Limits 1 ☐ Yes 2 No Director MD Baltimore Windsor Mill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 USA 3633 Marriotts Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No SpeAfrican-American 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foster Care Baltimore City permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If Item 27 is marked other the any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Hall Barbara L. Stewart 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Gainer / Mother 6221 Pimlico Road, Apt. B. Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 11-6-07 Baltimore, MD 4 □ pohation 5 □ Other (Specify) 22. Name and Address of Facility ature of Funeral Service License Wylie Funeral Home P.A. of Balto. Co. Tanda 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician resulting in death) /Medical Due to (or as a consequence of): Examiner 2 llu Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760. signed by the attending physician d be detached for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director. After this certificate has been so completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 2 Z NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 mpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road, Randalls town, HD 21133 32 Registrar's Signature

lour

2007

29c. License number

29d. Date signed (Month, Day, Year)

November 5, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician DELL, Christopher 2007 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Columbia Howard County General Hospital Howard Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□M 2XF Months Hours Min 89 5-7-1918 Director 218-22-8116 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anones. 10c. City, Town or Location 10a State 10h County 10d Inside City Limits 1 ☐ Yes 2 X No Director MD Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 21043 5074 Bonnie Branch Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: African-American 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4th Seanstress Montgomery Wards 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton Griffin Carrie Bowie ပ္ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5074 Bonnie Branch Rd., Ellicott City, MD 21043 Ireatha Chenault/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 KRemoval from State Mt. Moriah B/C Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11-11-07 Greenwood, SC 22. Name and Address of Facility lie F/ H P.A. of Baltimore County 21. Signal re of Funeral Service Licenses TaNACH 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ac. Myocardial infarction **Physician** 72 hours /Medical Due to (or as a consequence of): Renal failure **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner seplic shock death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death the 9□Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No After this of funeral dire ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. Box 68760, or Attending Physician:

Baltimore, Maryland 21215-0036

death. within 24 hours after death

To the Funeral Director:
completely filled in by the

State

29a. Certifier (Check only one)

29b. Signature and title of certifier

M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00060345

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 2007

Patuexent Parkway Columbia MD, 21044 31. Date filed (Month) 32, Registrar's Signature

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State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

31. Date filed (Month

5+vce+

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 5, 2007 **Physician** Melbourne T. L. Downing, Sr. 3:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Presbyterian Home of Maryland Towson Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2□ F 1/18/1913 Maryland 215-03-7804 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural;" or flems 23a or 28a-f show any injury or other traumatic event, the Medical Eyaminas marked. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Timonium MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 East Timonium Road 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Firm President 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Albert Downing Minnie Elizabeth Lastner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 400 East Timonium Road Timonium, MD 21204 Wesley F. Downing/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/7/2007 Parkwood Cemetery Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21204 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovasiala **Physician** das /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been s , page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performe To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 428 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 254 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier Attendity

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

32. Reistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kenneth m. Green, m 670/N. Charles H., Sute 4105 Bythmon, mo 21204

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 2007 Zı. Nov. Eileen A. Ebmeier 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson Gilchrist 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 1 □ M 2 □ F Yrs. 19 1921 WI Nov. 86 397-09-6799 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 □Yes 2□No Director Timonium Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 USA 2525 Pot Spring Rd. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: 2 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Dietrich Edward Mueller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4716 Clermont Mill Rd., Pylesville, MD 21132 Mary Gernand/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 11/9/87 20a. Method of Disposition ¶ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 22. Name and Address of Facility 21. Signature of Fune Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Michael a **T**lagle Approximate Interval Between Onget and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 □ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Pes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Fell going To the Bathroom Injury 5 ☐ Pending investigation No Jember 1, 2007 2:30 AM 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2525 Pots pring Road, Cockeysville, W 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Mercy Ridge Apart next

Examiner or Attending Physician: The law requires that the death certificate be executed attending physician Division or Vital Records, P.O. Box 68760 the been signed by this After t death. 24 hours after death e Funeral Director:

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

death v

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: if then 27 Is marked other then any injury or other trainment.

Physician

/Medical

Examine Physician/Medical þ Completed Be Certification: To

within 2

Medical

31. Date filed (Month, Day, State

29b. Signature and title of certifier

30. Name and address of person

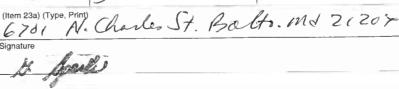
3 Suicide

29a. Certifier

4 ☐ Homicide

6701 Begistrar's Signature 32.

who completed cause death (Item 23a) (Type, Print)



determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

175205

29d. Date signed (Month, Day, Year)

November 5, 2007

7. Age (In yrs. last birthday)

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Timonium

Days

4c. County of Death

Baltimore

Birthplace (State or Foreign Country)

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at
--

Physician

/Medical

Examiner

Funeral

4a. Facility Name (If not institution, give street and number)

1500 Long Quarter Court

6. Sex

5. Social Security Number

Physician /Medical Examiner

ending physician and use as the burial-tran attending physician for use as the buris detached pe peen page 2 funeral

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

filled in by

To the Hospital o within 24 hours aff To the Funeral D completely filled in

8. Date of Birth (Month, Day, Year) Months 1 □ M 2 🛛 F 55 Yrs 219-60-7306 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Baltimore Timonium 1 □ Yes 2¥ □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 1500 Long Quarter Court Funeral 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Housewi fe Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard FauntLeRoy Angela Mackarevwicz ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Long Quarter Court, Timonium, MD 21093 Brian Ciany/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-07-2007 Timonium, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final lars and 3 mos disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 🗙 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ို 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) State NOV 0 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Gayana Nember 5 2007 Fertetta /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Geln Burnie Anne Arundel if Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months 1 ☐ M 2 🗓 F Days Director 217-22-4215 83 1924 West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 7 is marked ot er than "natural", or itema 23a or 28a-f sho traumatic evert, the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Brooklyn Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 405 Waverly Avenue 21225 USA 11. Maritai Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 3 Married 2 No 1 ☐ Yes 2 € No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F Pages 1 and 2 should be nent of Health and Mental Benjamin Davis Grace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori Fertetta (Daughter) 405 Waverly Avenue, Brooklyn Park, MD. 21225 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 → Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 11/9/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityLoudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 Pour Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3□ DOA this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and ac

31. Date filed (Month, Day, Year)

NOV 0 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** FARMER 9-20 AM WILSIE NOVEMBER 4, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UNIVERSITY SPECIALIST HOSP BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1**X**M 2□ F Months Days Hours 80 241-32-*5535* 05/13/1927 NORTHCAROLINA Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1529 WINSTON AVE. 21239 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, GiveX 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER JUNK YARD 3rd17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DOLLIE COOPER FLOYD FARMER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WILSIE FARMER, JR. (son) 3420 FLANNERY Lane Balto, Md. 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) TY CEMETERY NOV.9,2007 BALTIMORE, MD.
22. Name and Address of Facility 21. Sonature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME Part 1. Enter the disease, or complication, that caused the d. tr. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate interval Between on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): KIDNEY DISEASE CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner FALLURA RESPIRATORY Due to (or as a consequence of): MELLITUS DIABETES Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide

be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760, The law requires that the death certificate attending properties for use as signed by the a d be detached f cate has by page 2 s

Hospital or Attending

Funeral

Director

show la or 28a-f sho

ral", or Items 23a Examiner must b

is merked other

Important: If Item 27 any injury or other tr.

Physician /Medical

Examiner

Pages 1 and 2 should be nent of Heelth and Mental

Baltimore, Maryland

director, funeral After within 24 hours arter community to the Funeral Director: Aff

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

St. Baltimore, Md

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D65152

29d. Date signed (Month, Day, Year) NOVEMBER, 4th 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ayodele Ayodo ZZ S. Gr S. Green

and manner stated.

31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

29a. Certifier

Medical

State Registrar



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 28b per me, g873_11/08/07dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2007 adeline GINNEMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner 5. Social Security Number Balhmore C Daylview Medica If Under 1 Year Date of Birth (Month, Day, Year) 4-/2-/93/ Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days 218-26 Months Min 1 □ M 2 🖼 -0926 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Balhmore ru nda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S. A 102 21222 Funeral VENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker OWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked oth Jury or other traumatic even ဂ္ Helter Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GINNEMAN -AVON AVENUE a Dundalk, md 21222 husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department or important: If i rematery 11-1-07 Balhmore 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bradley - Ashton Funeral Home, 21. Signature of Funeral Service Licensee PA, 2134 WILLOW SACING Sittle 14 Rd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car liac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Adal Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner chi Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) The law requires that the death certificate be executed cheter Me the burial-tran Due to (or as a consequence of) physician Physician/Medical EXAMINER for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month signed by the a 5 Other (specify) PPROVED 9 Unknown CENTRICA Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s autopsy performed 2 No Physician: 25. Was case referred to medical examiner?
1 ▼ Yes 2 No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury
(Month. Day Year) within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗹 No **Unknown** M 10-17-07 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2/222 4 ☐ Homicide determined 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospital within 24 hours a 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055171 2910 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sebastian

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

3023

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend it am 18 per 18 per 19 2873 11 1 1 2 0 7 35846 State Registrar Amend #19b,perInf, 0873, 11/29/07 Opertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}4, 2007 **Physician** NINA November 5:25 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Health-Lochern Baltimore N/A 8. Date of Birth (Month, Day, Year) Feb. 17, 1927 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours 218-22-5883 Maryland 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ty∐Yes 2 No Director Md. N/A Roland Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Deepene Road 21210 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William E. Heck Karmann Elizabeth Rarmann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anne Torgerson/ Cousin Clifton Ave. Baltimore, Md. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Moreland Mem. Pk. 11-9-07 Baltimore, Md. 21. Signature of Fune Service Licensee 22. Name and Address of Facility Funeral Home, 1050 York Rd. Towson, Md. plications in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or simplication shock, or heart failure. List only one continues the shock of Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (R) SCa alignan utoma disease or condition resulting in death) /Medical Due to (or s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physiclan and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Iniury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 24 29b. Signature nd title of certifier 29c. License number

State Registrar

M

8 2007

30. Name and address of

31. Date filed (Month, Day, Year) NOV 0 8

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Congress.

ASHINGTON

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 35847

		1- For State Registrar	•	icate of Death	ia wentan	Reg	. No.	
Physic		Decedent's Name (First, Middle,Last)				2. Date of Death	Day Year	3. Time of Death
ledical Exam	uner	BRIAN T. HARRIER				October 23	2007	0950 hrs
,		4a. Facility Name (if not institution, give street and number	r)		or Location of Deat	h	4c. County of Dea	th
		135 West Main Street Apt 2		Elkton				
Funera		5. Social Security Number 6. Sex 7. A	ge (In yrs. last i	birthday) If Under 1 Ye Months Da		s. 8. Date of Birth	(MM/DD/YYYY) 9. B Fore	sirthplace (State or eign
Director		161.52.6425 1XXM 2 F	37	Yrs.	ys Tiodis IVIII		, 1970 C	Country) PA
	1	Usual Residence of Decedent						
v any	1	10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
and shov shov	5	MD CECIL	ELKT	TON				1 Yes 2XX No
Aaryland 28a-f show I at once,	Director	10e. Street and Number		10f. Zip Code	-	100	. Citizen of What Co	untry?
the N a or i	吉	135 W. MAIN ST.		21921			USA	
with the Maryland ms 23a or 28a-f sho be notified at once.	교	11. Marital Status 12. Was Deceder	nt Ever in U.S.	13. Was Decedent of H			14. Race - Ame	erican Indian, Black,
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f shu al Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces	s? 2 No	If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	White, etc.	
fter d I", on	II E	3 Widowed 4 X Divorced If Yes, Give Year	L NO	1/X Yes 2 N	o specify: [[]]	5 1988- 199	Specify: WI	HITE
urs a tura antir	d b	15. Decedent's Education (Specify only highest grade of	ompleted) 16	Sa. Decedent's Usual Occup	ation (Give kind of	work done	16b. Kind of Business	s/Industry
72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or	r 5+)	during most of working lif	e. DO NOT use re	tired)		
036 thin ne thau	臣	12	i	TANK CLE	ANUP		RAILCAF	₹
5-0 ed w Hygie other	<u>5</u>	17. Father's Name (First, Middle, Last)				e (First, Middle, M	aiden Surname)	
21215-0036 John Per Great American death Mental Hygiene marked other than "natural", or the event, the Medical Examiner must	Be	GEORGE HARRIER			MACKINA	SETTE HARRI	ED	
ould ould I Mes	ြို	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Address (Stre				te, Zip Code)
MD id 2 sho lith and m 27 is aumati		MACKINA HARRIER M	OTHER	301 W. FIFTH ST	REET. EMPO	RIUM. PA 15	834	
ore, MD 21215-0036 s. I and 2 should be filed within 72 f Health and Mental Hygiene. If item 27 is marked other than 'ner raumatic event, the Medical		20a. Method of Disposition	20b. Plac	ce of Disposition (Name of c matory or other place)			20c. Location - City of	or Town, State
ages nt of nt of		1 Burial 2 XX Cremation 3 XX Removal from S	olale	EO'S CATHOLIC CE	METERY NOV	3 2007	DIDCEMAY I	PENNSYLVANIA
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	P1. L	22. Name and Addre		. 3,2007	KIDULWAI, I	EININGTEVANTA
Baltimore, MD 27 permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is me injury or other traumatic er			NO11/0	FINK FUNERA	L HOME, P.		ND 04064	
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/Medica		failure. List only one cause on each line.						Between Onset and Death
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		b	sequence or).					
	<u>=</u>	if any, leading to immediate Due to (or as a con	sequence of):					
	盲	(Disease or injury that initiated						
i	Examiner	events resulting in death) Last Due to (or as a con	sequence of):					
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760, Trate be physiciate but the buria	Įξ	23c. If yes, outco	ome of pregnan	icy			23d. Date of delive	
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of Vital Records, P.O. Box 68. ng Physician: The law requires that the death certifi After this certificate has been signed by the attending meral director, page 2 should be deached for use as;						1 Yes	2 No 3 Pr	robabły 4 🗸 Unknown
ds, equire	Completed					24a. Was a	n 24b. Were	autopsy findings available
SOF faw r has b						autops perform		o completion of cause of
Vital Rec sysician: The B his certificate B director, page				_		1 ✓ Yes 2		
ion of Vital Rectending Physician: The leath for: After this certificate the functal director, page	B B	25. Was case referred to medical examiner?		26.Pla	ce of Death (Check	(only one)		
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ViSi or At iter d] ≝		Injury - At home	e, farm, street, factory, office	building, etc.			Rural Route Number, City
Divisi pital or Att ours after de eral Direct filled in by	Certification:	4 Homicide determined (Specify)				or Town, St	ate)	
Divis the Hospital or At hin 24 hours after d the Funeral Direc mpletely filled in by		29a. Certifier 1 Certifying Physician: To the best of						
Division To the Hospital or Attendability and the Hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of ex	amination and/					
1 1 0 S	Ĭ.	29b. Signature and title of certifier		29c. Lice	nse number		29d. Date signed (A	Month, Day, Year)
12)		(OLYAP II ON O)	dia	0.0	C.M.E.		October 24, 20	07
	1	30. Name and address of person who completed cause of	death (Itom 22	(a)				
V	1	Carol Allan, MD Assistant Medical Exa		ಣ) 11 Penn Street, Baltir	nore, MD 212	01		
	\		rar's Signature			·		
	1016	31. Date filed (Month, Day, Year) 32. Jegist	_ o orginature	6				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Laura May Hutzler 2007 November 6 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore N/A HOSPITA If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 □ M 2**X**□ F 86 Jan 1, 218-03-6345 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. Counfy 10d, Inside City Limits 1 ☐ Yes 2X No Anne Arundel Maryland Curtis Bay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1348 Hollow Glen Court 21226 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Albert Randel Anna Summers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gary Hutzler, Son 1348 Hollow Glen Court Curtis Bay, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) Crest Lawn Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/09/07 Marriottsville, 21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a consequence of): Heart tailure exacerbot 1 days Stenosi tortic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Atrial Fibrillation Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

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Funeral

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filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be flied will Department of Health and Mental Hygient Important: If item 27 is marked other that any injury or other traumatic event, the 1 once.

Maryland 21215-0036

Baltimore,

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physician and sthe burial-trans attending ph ed by the a detached t signed to page 2 s certificate this certifica funeral

Physician/Medical

Completed

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Medical Certification:

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

Lynn

31. Date filed (Month, Day, Year)

6 Could not be determined

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NOV 0 8 2007

P.O. Box 68760. Records, Vital Hospital or Attending Physician: o

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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State Registrar 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DS857

Avenue Baltimore

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Caton

and manner stated.

900

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35849 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Eartha Dell Hall 11 03 07 1930 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Cheverly If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. P.G. Hospital 5. Social Security Number 6. S 8. Date of Birth (Month, Day, Year) 7-20-24 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 □ F Director 83 S.C. 579-68-6056 Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director MD P.G. Capital Heights 10e. Street and Number 10g. Citizen of What Country? Funeral 20743 1207 Addison Rd #130 A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes Completed by Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Item 27 is marked other than Domestic Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be မ Minnie Hall Dan Rowe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Minnie Hall-Williams 20774 602 Drumsheugh Ct. Upper Marlboro, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/9/07 Brentwood, MD Lincoln Cem. 22. Name and Address of Facility The House of Williams 21. Signature of Funeral Service Licenses 814 Upshur St., NW, Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Physician** /Medical Examiner sician al burial-t has e 2 s certificate ha

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760; After 1 d in by the within 24 hours aft To the Funeral Di completely filled in

Immediate Cause (Final disease or condition resulting in death) a. Resistant pseudimonas weethon											
	resulting in death)	Due to for se a consequence of:			1						
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ial	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month										
Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown										
7	Part II. Other significant conditions of	use contribute to	the cause of death?								
0	Bilateral MAR	□ No 3 □ Pro	bably 4 Hinknown								
ete		hma- apparent revent +	ache e al à	24a. Was an	24h Were aut	opsy findings available					
	/	min significant of	oug culla	autopsy performed?	prior to co	or to completion of cause of					
3	Decubly			1□ Yes 2 No	1 ☐ Yes	2 No					
g R	25. Was case referred to medical examiner?	Hospital:	26. Place of Death								
0	1 Yes 2 Ho	1 Inpatient 2 EH/Outpatient 3		ne 5 Residence	6 □Other (Speci	ify)					
إ	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at 2 Work?	8d. Describe how inju	y occurred						
ğ	2 ☐ Accident investigation		1 ☐ Yes 2 ☐ No								
2	3 Suicide 6 Could not be 4 Homicide determined	8f. Location (Street ar City or Town, State		ral Route Number,							
Certification:		"/									
	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, death occuniner: On the basis of examination and/or investig	rred at the time, date and place, a	nd due to the cause(s	and manner as	stated.					
edical	one)	and manner stated.	auon, in my opinion, death occurre	ru at the time, date an	u piace, and due	to the cause(s)					
Ž	29b. Signature and title of certifier		29c. License number	29d. Da	te signed (Month,	Day, Year)					
		D'yce	20043662	11	13/07						

State Registrar

31. Date filed (Month, Day, Year) NOV 0 8 2007

Boyce

VilleAm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Cheverly MD 20785

Division or Vital Records, P.O. Box 68760,

or Attending Physician: To the rices.

within 24 hours after death.

To the Funeral Director: Aft Hospital

3 ☐ Suicide 6 ☐ Could not be 4 Homicide

(Check only

29b. Signature and title of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

SOUTH CATON AVENUE, BALTIMORE, ND, 21229

NOVEMBER 05 2007

State

12

Please Type or Print in Black Indelible Ink Ensure All Conies Are Legible

by G. Hicks			ate of Maryl	and / Dep	artment of	f Healt	h and					007	358	₹5
		1- For State Registrar	- 1 4\	Ce	rtificate o	Death	7		- 10		g. No.		Time of Death	
Physicia ledical Examin		1. Decedent's Name (First, Middle Roy G. Hicks								Date of Deat Month November			0830 hrs	
		4a. Facility Name (if not institution		iumber)		4b. City, T	own, or Lo	ocation of I		November	4c. County o	f Death		\neg
/		Western Correctional					erland	,			Allegany			
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Unde	r 1 Year Days	If Under :	24Hrs. Min.		h(MM/DD/YYYY	Foreign	lace (State or	
Director	-	unk Usual Residence of Decedent	1 XM 2 F	48	Yrs	3.				8/13	/ 59	Count	ry) MD	
any	-	10a. State 10b. County			y, Town or Locat							10	0d. Inside City Lin	nits
1	5	MD N/A		B	altimo	re					1 Yes 2 No			No
Maryla 28a-f	원	10e. Street and Number				10f. Zip				10	g. Citizen of Wh	at Country	/?	
ith the Maryland 23a or 28a-f show notified at once.		1240 Glenwood				<u> </u>		1239			USA			
ath wi	Funeral	11. Marital Status 1 Never Married 2 M	Armed Armed	ecedent Ever in I Forces?		as Deceder es, specif				cify Yes or No- ican, etc.)	White	e, etc.	n Indian, Black,	
fter de	- 1		orced If Yes, Give You		1	1 Yes 2 X No specify:					African ^{Specify} American			
nours a	leted by	15. Decedent's Education (Spe	cify only highest gr		16a. Deceder	nt's Usual (16b. Kind of Bu			
1215-0036 Id be filed within 72 hours afthen 14 lygiene. Insteed other than "natural" event, the Medical Examing	Bet	Elementary/Secondary (0-12)		(1-4 or 5+)			U			-,	n 1.1.			
21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medical	Compl	17. Father's Name (First, Middle	Last)	6		Writ		8.Mother's	Name (I	First, Middle, N	Publi Maiden Surname		ons	
215 be file ntal H rked o	8	Daniel J. Hi	cks, Sr	•						O. Br				
D 21 should and Men	Tab. Mailing Address (Street and Number													
and 2 shc ealth and tem 27 is	-	Kate O. Hick 20a. Method of Disposition	s/motne		. Place of Dispos					Balt1	20c. Location -		21239 own, State	
Baltimore, pernit. Pages I an Department of He Important: If ite		1 X Burial 2 Cremation	3 Removal	from State	crematory or of rbutus	ther place)			11/0	9/07	Λ b ±	- N	4 D	
altin nit. Pa artmer sortan iry or		4 Donation 5 Other Si 21. Signature of Furjeral pervice		10							Arbutu			-
Dep De Militia		17=	-6		H. 5	ari 126	P. C Bela	Close ir F	e Fι Rd.	ıneral Balt.	Servi MD 21	ce, 206	P.A.	
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.		h. Do not enter	the mode o	of dying, s	uch as car	diac or i	espiratory arr	est, shock, or he	art	Approximate Inte Between Onset	
caminer	Ì	Immediate Cause (Final disease or condition resulting in death)		ounds of Ex								_	Death	1.4
		Sequentially list conditions,	b	a consequence	01).									
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14	Exam	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	of):									
be executed ician and urial - transit	dical E		d											
io, te be ex ysiciar burial	ledic	UNPENDED	AMENDED								22d Data of	dolivon		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ne 1 Live	s, outcome of pre birth	2 F	etal death	3	Ectopic	pregnan	су	23d. Date of Month	Da	y Year	
eath ce attence for use	Sici		CDOWD T	gnant at time of one	death 5 0	ther (Spe	cify)				1			
that the de ned by the detached f	Phy	Part II. Other significant condit	and the second		resulting in the	underlying	cause gi	ven in Parl	t 1.	23e. Did to	obacco use contr	ibute to th	e cause of death	?
, P.O ires that t signed by	ğ ğ									1 Ye	s 2 🗸 No 3	Proba	bly 4 Unkno	wn_
Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be a page 2 should be a second the second of t	Completed									24a. Was autor	sy	prior to cor	psy findings avai mpletion of cause	
tal Reco	ĕ									1 Yes		death? ✓ Yes	2 N	٥
Vital Recystician: The Inis certificate I	Be	25. Was case referred to medica examiner?	Hospital:				10	of Death (0 Other				4 011		
ing Physic After this funeral dire	리	1 ✓ Yes 2 No 27. Manner of Death	28a. Da	Inpatient 2 te of Injury	ER/Outpatien			at Work?		Home 5 28d. Describe	Residence 6 how injury occur		Scene	
on C ending ath. or: Af he fun	ţį	1 Natural 5 Pen	ding FOUN	nth, Day,Year) I D :	FOUND: 0805 hrs			es 2 🗸 I	ļc	Subject cut				
Division pital or Attent ours after death teral Director:	ifica			ace of Injury - At		eet, factory	, office bu	ilding, etc.	- 1	28f. Location (er or Rura	al Route Number,	City
Di spital nours a neral I	Certification:	4 Homicide dete	rmined (Specif	y Jail/Pena					1	3800 McMui	len Highway, (Sumberla	ind, MD	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		19.110	hysician: To the b miner:On the basi		-									
To T	Medical	29b. Signature and title of certific	and manner				c. License				29d. Date sign			
			N. It				O.C.N	I.E.			November	3, 2007	7	
2	ł	30. Name and address of persor												
4			outy Chief Med			nn Stre	et, Balti	more, N	/ID 212	201				
Sta Regist		31. Date filed (Month, Day, Year)		Registrar's Signa	ature model	20								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35852 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Miner 12:50 AM 01 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Paltimore Rehabilitation Extended care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May6,1923 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F Davs Hours 723-16-2778 84 Massachussetts Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show 1XYes 2 No must be notified Director Baltimore Md. n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 21231 U.S.A. 2108 Boston Street Apt.207 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1XX Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 0 1 ☐ Yes 2 ☐XNo White þ Specify: 3 Widowed 4 ☐ Divorced 'naturai", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than , Elementary/Secondary (0-12) College (1-4or 5+) 8th Truck Driver Best Battery Com. alth and Mental Hygie 27 Is marked other the r traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elsie M. Miner Harry Α. Hubbard ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Donna Mazan / Granddaughter 183 Cold Stream Trail Felton, Pa. 17322 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MBurial 2 ☐ Cremation 3 ☐ Removal from State 11-9-2007 Baltimore, Maryland Loudon Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Ave. Baltimore, Md. 21222 Tholmat 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) aryngeat unknown **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 □ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director
completely filled in by the To the I

6 Could not be determined

4 Homicide 29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John S. Lah, Lock Raven Bordevard, Baltimore, Maryland 21218 3900 M.D.

31. Date filed (Month, Day, Year)

NOV 0 8 2007

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature

Registrar

amend stems 10b c per fb 8873 11 8 07 and Mental Hygiene 1 - For State Registrar Reg. No.2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 17:13 AM Physician ANNIE SALKSON NINFUBER 6,2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALSIMDRE RANDALLSTOWN LENSER VIUZHWES HOSEMAL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 215-30-8896 Director 7·a0·1934 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County show Balto. ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 ☐ NO Completed by Funeral Director Randallstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be more. U.S.A 3530 Mesource a1133 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify. Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Soldering Manufacturino 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be c Clenon ٩ eola 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackson / Daughter 4113 Century Towne Ad Archallstown, MD 21133
ace of Disposition (Name of Date 20c. Location - City or Town, State lheleasa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 D Burial 2 □ Cremation 3 □ Removal from State Arbutus Cemetery 11. Id. 01 Daimir wie 22. Name and Address of Facility Vougnn C. Oreene Funeral Services 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 4905 York And Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARTERIOS CLERDTIL CAROJOYASLVLAR **Physician** /Medical Due to (or as a consequence of): **Examiner** Some nitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certific ral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0024970 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLO LOURS ROAD RANDALLSSO 401 Régistrar's Signature State BUHR! Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08603 State of Maryland / Department of Health and Mental Hygiene John Joseph Koontz, Jr. Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0855 hrs Month November 5, 2007 John Joseph Koontz, Jr. Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Randallstown 3004 Offutt Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Numbe **Funeral** Foreign Hours Days Director MD 1 X M 2 Yrs 02/10/1975 217-17-1016 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Yes 2 X No Randallstown to thealth and Mental Hygiene.

1. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Me iteal xaminer must be notified at once. MD Baltimore 10g. Citizen of What Country? 10f. Zip Code Direct 10e, Street and Number 21133 United States 3004 Offutt Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or Nodeath with 12. Was Decedent Ever in U.S. Funera 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married Yes 2 X No Specify: White Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after Divorced f Yes, Give Yea Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 Electrical/Laborer Electrician 5 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brenda Glensky John J. Koontz, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 3004 Offutt Road, Randallstown, Maryland 21133 Mrs. Gina DeMaria-Koontz (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/09/2007 Elkridge, Maryland Meadowridge Memorial Donation 5 Other Specify. 22. Name and Address of Facility Hubbard Funeral Home, Inc. permit. 21. Signature of Funeral Service Licensee Maila T. Baltimore. Maryland 4107 Wilkens Avenue. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) If any, leading to immediate Examine cause. Enter Underlying Cauce (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown ò Completed 24b. Were autopsy findings available 24a. Was an has been prior to completion of cause of autopsy death? performed? No r this certificate h Yes 2 1 🗸 Yes 2 26 Place of Death (Check only one) 25. Was case referred to medical Be Other, Residence 6 V Other: Scene examiner? Hospital: Nursing Home 5 Inpatient 2 ER/Outpatient 3 DOA 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury After 27. Manner of Death Subject shot self Certification: FOUND: Yes 2 V No Natural Pending Director: Nov 5, 2007 0850 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 🗸 Suicide Could not be or Town, State) 3004 Offutt Road, Randalistown, MD determined (Specify) Backyard Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number November 6, 2007 O.C.M.E. Withullim 30. Name and a dress of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD 31. Date filed (Month Registrar's Signature 8 State 200

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 35855 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Edward Anthony Kachinskas NOVEMBER 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 1 M 2 □ F Days Months Hours Min. 215-12-8317 85 May 16, 1922 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Arbutus 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1208 June Road 21227 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 1 No If Yes, Give Year or Dates: 2/45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: white 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Freight Handler Trucking 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Kasinskas Rose Matuseviciute 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Kachinskas/Daughter 1208 June Road Arbutus, MD 21227 20b. Place of Disposition (Name of Meadowridge Memorial Park 20a. Method of Disposition Date 1 X Burial 2 □ Cremation 3 □ Removal from State 11-8-2007 4 ☐ Ponation 5 ☐ Other (Specify) Elkridge, Maryland Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 21. aignature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTION MYOCARDIAL 20 MINUTES Due to (or as a consequence of): Sequentially list conditions, if any local to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Place of injury - At home, farm, street, factory, office building, etc. (Specify)

To the Hospital or Attending Physician: after death.

I Director: After the in by the funeral

Examine Physician/Medical Be Completed by ဥ Medical Certification:

Physician

/Medical

Examiner

Funeral

Director

28a-f show ıms 23a or 28a-f sho ır must be notified a

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

7 Is marked other than "natu traumatic event, the Medical

permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any Injury or other trau once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

				0100
25.	Was case examiner?	referred	to	medical
	1 ☐ Yes		-	

29a. Certifier

3 Suicide 4 ☐ Homicide

29b. Signature and title of contifier

CHARLES

6 ☐ Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

D0051865

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

CURTIS

JONES HOSPITME BATTIMORE

State Registrar

31. Date filed (Month, Day, Year) NOV 0 8 2007



n 24 hours af e Funeral D letely filled in

within 2

3+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	,	Cer	tificate of l	Death		Reg. No 2 0 0	7 35856
	Dhysisi		1. Decedent's Name (First, Middle, L	ast)				2. Date of Do	Day Ye	3. Time of Death
12.00	Physicia /Medic	al	Carroll Roger Lucas					Napm	ber 2 20	
	Examin	er	4a Facility Name (If not institution, g	ive street and number)	1.0/1/	4b. City, Town, or	Location of Deat	h	4c. County of D	peath () ()
JA 3			5. Social Security Number 6.	Sex 7. Age (II	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs			Birthplace (State or Foreign
н	Funeral Director		215.07.1113	1 /X M 2□F 96	Yrs.	Months Days	Hours Min.	(Month, D.		Country) MD
	D		Usual Residence of Decedent		07 T	-41				10d. Inside City Limits
	anylan show d at	_	10a. State 10b. County	10	c. City, Town or Loc	ation				1 ☐ Yes ¾∑ No
	ne Ma 8a-f s	Director	MD Anne Arun	del	Hillersville	10f. Zip Code			10g. Citizen of What	
	a or 2		10e. Street and Number			21108			USA	Country
	eath ns 23 must	Funeral	1147 Cecil Ave	12. Was Decedent Eve	r in U.S. 13. V	Vas Decedent of H	lispanic Origin? (Specify Yes or N		American Indian,
(0	or iter ainer	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes ※ No If Yes, Give		Yes, specify Cuba	an, Mexican, Puei Specify:	to Rican, etc.)		Vhite, etc.
93	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Examiner must be notified at	l by	3√Widowed 4 □ Divorced	Year or Dates:					Specify:	White
5-0	be filed within 72 hours after death with the Marylan ttal Hyglene. cd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	15. Decedent's (Specify only highest t	Education grade completed)	(Give	ent's Usual Occup kind of work done OO NOT use retired	during most of wo	orking	16b. Kind of Busine	ess/Industry
121	within lene. than " he Med	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		Manager	-/		Baltimore	Business Forms
d 2	filed Hygi other ent, tl		17. Father's Name (First, Middle, La	st)	1 10110	, randget	18. Mother's Na	me (First, Middle	e, Maiden Surname)	
a	should be and Mental s marked o	To Be	Bernie Lucas				Ada Wan	tz		
Maryland 21215-0036	ages 1 and 2 should b nt of Health and Ment: t: If item 27 is marked / or other traumatic e		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailin	g Address (Street	and Number or F	lural Route Num	ber, City or Town, Sta	te, Zip Code)
Σ,	and 2 salth of 27 is		Helen V. Fifer		1147 C	ecil Ave, N	<u>Millersvil</u>			
ore	Pages 1 nent of Hi ant: If iter		20a. Method of Disposition 1 Burial 2 □ Cremation 3	1 Hemovai irom State 1	20b. Place of Disper cemetery, creft	1	ce)	Date	20c. Location - City	-
Ħ.	tmen tant: tant:		4 ☐ Donation 5 ☐ Other (Spe	cify)	Woodlawn Cer			7, 2007	Baltimore, N	10
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Puneral Service Li		148	Name and Addre	ral Home, Hwy S, Gl	P.A. en Burnie	, MD 21061	
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	Dhysisian	0 3	Immediate Cause (Final	14.1	1 (1)	+				Interval Between Onset and Death
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	Examiner		Constally list and distant	b						
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Box	eath corti		IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome pf	pregnancy	Teteniaeraanana			23d. Date o	
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o	g Physer this eral di	7: To	27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Time o				e how injury occurred	
ion	Attending P r death. ector: After by the funera	atio	1 Natural 5 ☐ Pending 2 Accident investiga	tion	ear) Injury		Yes 2 □ No			
Division	r Attend er death. rector: /	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be ed 28e. Place of injury building, etc.	- At home, farm, str (Specify)	eet, factory, office		28f. Location City or T	(Street and Number Town, State)	or Rural Route Number,
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	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director; After the completely filled in by the funeral	Mec	29b. Signature and title of certifier	and mainer state		29c. Licen	se number		29d. Date signed (Month, Day, Year)
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			30. Name and addres on erson w	ho completed cause of dea	th (Item 23a) (Type,	29c. Licen D4 Print) Llon	,	.	MA 7 11	n 4 1
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_	Regist	rar	NOV 0 8	ZUUI JOSEPH	AS ASSA	e Time				

Registrar DHMH 17 Rev 1/2001

			Please 1	Type or Print in Bla				_		
			For State Registrar	State of Maryland	/ Department Certificate			ene g. No2 N N 7	35857	
	%	-	Decedent's Name (First, Middle, Last))			2. Date of Death Month	Day Year	3. Time of Death	
	Physici /Medio	_	Joseph F. Lucke				Novembe:	r 4, 2007	3:27 P M	
Marine Comment	Examin	er	4a. Facility Name (If not institution, give Stella Maris Ho			own, or Location of Death nonium		4c. County of Deat		
	Funeral	,	5. Social Security Number 6. Sę	7. Age (In yrs. las	t birthday) If Under 1		8. Date of Birth (Month, Day,	9. Birt	hplace (State or Foreign	
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	Maryland -f show ifed at	tor	Usual Residence of Decedent 10a. State 10b. County Anne A	Arundel 10c. City, 7	Town or Location Linthi	icum			10d. Inside City Limits 1 ☐ Yes X☐ No	
	th the or 28a e notii	Director	10e. Street and Number		10f. Zip C		10	g. Citizen of What Co	ountry?	
	ath wi	ral	104 Shortcross Ro			21090		United S		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decede If Yes, specif	nt of HispanIc Origin? (S y Cuban, Mexican, Puert	o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
Baltimore, Maryland 21215-0036	thin 72 hou e. an "natura Medical E	Completed	15. Decedent's Edu (Specify only highest grad		life. DO NOT use	done during most of wor retired)		6b. Kind of Business/		
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Box	e death certificate be ex ne attending physician ed for use as the buria	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome pf pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	death 3 Ectopic pre			23d. Date of de Month	livery Day Year	
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or Vital Records,	e la has	Completed					24a. Was ar autops perform	y prior to ned? death?	utopsy findings available completion of cause of	
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or \	Physician: this certific ral director,	은	1 ☐ Yes 2 🗶 No 27. Manner of Death		R/Outpatient 3 DOA		1	ence 6 NOther (Spenier injury occurred	ecify) HOSPICE	
Ou	ding J. After fune	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury M	ic. Injury at Work? 1 □ Yes 2 □ No	200. 50001150 110	www.		
Division	or Atter after dea Director in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hom building, etc. (Specify)	ne, farm, street, factory,	office	28f. Location (St. City or Town	reet and Number or Fi n, State)	iural Route Number,	
	Hospital 24 hours a Funeral stely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physical Example (Check only one)	ysician: To the best of my knowl niner: On the basis of examination and manner stated.	rledge, death occurred a on and/or investigation,	at the time, date and plac in my opinion, death occ	e, and due to the caurred at the time, d	ause(s) and manner a ate and place, and du	is stated. le to the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.	29c.	License number	2	9d. Date signed (Mon	nth, Day, Year)	
	- > F 0		1-			174872	i	111510	7	

State Registrar

NOV 0 8 2007

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 35858 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year ear 0705 AM Dav 10 November MAY 200 4b. City, Town, or Location of Death 4c. County of Death N Himore If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Months Days Hours 17 M 2 □ F 72 26,1935 Feb. Iowa 10c. City, Town or Location 10h County Leon Tallahassee

/Medical 4a. Facility Name (If not institution, give street and number) Examiner ohns 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 483-38-7277 Director Usual Residence of Decedent the Maryland 10a State 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2 No Director Florida 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filled within 72 hours after death with tent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or Items 23a or? 3529 Gardenview Way 32309 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

¹X█X'es 2□ No Vet
If Yes, Give
Year or Dates: 32 years Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Independent Insurance Agent 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul R. Lear Grace Marie Hisson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Mae Lear Wife 3529 Gardenview Way, Tallahassee, Florida 32309 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State Gulf Coast Crematory 11/09/07 Tallahassee, Florida 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a insequence of): Irres disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (ords a consequence of): Meso and Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) M.D

Registrar

State

31. Date filed (Month, Day,

Physician

Horkins Huspita

32. Strar's Signature

DD N. Wilfe St. Baltimore, Md 2128

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) .Month Year **Physician** 5, 2007 4c. County of Death November /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore 24 Hrs. NIa Future Care Sandtown Nursing Home 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year Age (In yrs) last birthday) Hours 1 □ M 2 🕏 F **Funeral** Days Min. Months 421-28-136 Usual Residence of Decedent Director 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show 1 wes 2 No 7 is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Examiner must be notified Director Mary land more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 No If Yes, Give Year or Dates: 14. Race - American Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 Married 2No 1 🗌 Yes Specify Baltimore, Maryland 21215-0036 Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) d 2 should be filed within; th and Mental Hygiene. 7 is marked other than "! Elementary/Secondary (0-12) College (1-4or 5+) Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) eman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Spouse) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Balton, noward 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Wina Forest 4 □ Donation 5 □ Other (Specify) 21. Sunatur of uneral Service Insee **Sacility** Honor 21216 sisses L. M. Tatell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ALZHEIMER'S DEMENTIA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death cartificate be executed the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ttending phor use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes HYPERTENSIVE CARDIO VASCULAR Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? /es 2 1 No 2 No 1 ☐ Yes 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this (28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 27. Manner of Death After t Injury 1 Natural 5 Pending investigation of Funeral Director; Aff le Funeral Director; Aff pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide 1 Verertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D5059107 11-6-2007 $M \cdot D$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21136 210

State Registrar

31. Date filed (Month, Day, Year)

UMA

BUSINESS LENTER DRIVE 32 Registrar's Signature

REISTER STOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day husc u FO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Y) Dec. 19, 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🔀 F Mary land 215-10-8298 93 Dec. 1913 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "naturat", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 👿 No Baltimore Be Completed by Funeral Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8832 Walther Blvd. 21234 USA . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frederick J. Tausendschoen Augusta E. Bergund 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jerilynn A. Elliott/ Dtr. 4506 Fieldgreen Rd. Baltimore, Md. 21236 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 11-9-07 4 □ Donation 5 □ Qther (Specify) Baltimore, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Furferal Service Licentee 23a. Part1. Enter the disease, or comshock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest rone cause on each line... Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Division or Vital Records, P.O. 9□Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes Other: 2 2 10 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date, signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) Name and address of person wh 8800 Blowwatherul 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

NOV 08

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08426 State of Maryland / Department of Health and Mental Hygiene Joshua Montgomery 1- For State Certificate of Death Rea. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day October 30, 2007 2309 hrs **Medical Examiner** JOSHUA MONTGOMERY 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Baltimore Washington Medical Center Annapolis 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Months Days Hours Min Country) Director NOV. 27, 1981 1XX M 2 F 236.21.3171 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 y xNo s 23a or 28a-f show e notified at once. GLEN BURNIE MD ANNE ARUNDEL with the Maryland rector 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 這 110 THOMAS RD 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Mantal Status must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 XX Married Never Mamed Yes WHITE 2XX No specify: Specify: If Yes. Give Year Yes 4 Divorced Pages 1 and 2 should be filed within 72 hours after 27 is marked other than "natural", umatic event, the Medical Examiner ğ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 GARY'S GRILL of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MILDRED THERESA BRISON JOSEPH P. SCOTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1303 UNION AVE., BALTIMORE, MD 21211 ADRYON MARIE DECARLO WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 XXCremation 3 Removal from State NOV. 3, 2007 BALTIMORE, MD BAYVIEW CREMATORY INC. Donation 5 Other Specify Si at re of Funeral Service 22. Name and Address of Facility FINK FUNERAL HOME, P.A. CRE MOT148 426 CRAIN HWY CLEN BURNIE MD Approximate Interval Part I. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and Death M dical Cardiac arrhythmia Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical AMENDED #23a.27.perME.g875. 1/7/08 TT X UNPENDED Hospital or Attending Physician: The law requires that the death certificate be 124 hours after cleath.
Funcial Director: After this certificate has been signed by the attending physicis alely filled in by the funeral director, page 2 should be detached for use as the buria Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Dav Year 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 2 Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? ✓ Yes 2 2 No 26.Place of Death (Check only one) 25. Was case referred to medica Be Other₄ examiner? Hospital: 1 / Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 DOA 1 Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification 1 X Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

To the

29b. Signature and title of certifier

Donna M. Vincenti, MD

31. Date filed (North), Dan Year,

Contact to

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Dav. Year)

November 1, 2007

and manner stated

OCME

Assistant Medical Examiner

32: Registrar's Signatur

Donna m Incenti, m.D. 30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 29&30, perMD, g873, 11/8/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Nicholas Smith Meekins, Jr. October . 31 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Charlestown Care Center Catonsville 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Months **X**☐ M 2 ☐ F Director 85 215-01-2825 1922 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant; If Item 27 is marked other than "natural", or Items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2▼ No Baltimore **Funeral Director** Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 709 Maiden Choice Lane, RG208 United States 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 XYes 2 No If Yes, Give Year or Dates: White 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) <u>Postal Service</u> <u> Letter Carrier</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Smith Meekins, Sr. Louise Ellwood ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1677 Brookhouse Ct, BR225, Sarasota, FL 34231 Robert Blyth - Stepson Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 Dagation 5 Other (Specify) permit. Page Department o Important: If any Injury or once. West Arundel Crematory 11-2-2007 Odenton, MD 21. Signatur of Funeral Sen 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER OF UNENOWN **Physician** METASTATIC 10 NTUS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Physician/Medical Examiner burial-trai Due to (or as a consequence of): physician the as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached i 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 0 page certificate 1□ Yes Physician; 25. Was case referred to medical examiner? After this certific funeral director, 26. Place of Death (Check only one) Be Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident s after death. 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Division or Vital Records, Hospital or Attending

To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b. iex1

Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and tide of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7)

Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

BITHEL 701 Maiden Choice Lane Catonsville, MD 21228 31. Date filed (Month, Day, Year)

and manner stated.

State

DHMH 17 Rev 1/2001

State Registrar

NOV 0 8 2007

Q.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D43346

Place

11.7.07

Baltimore no 21217

State Registrar

m

29b. Signature and tipe of certifier

31. Date filed (Month, Day, Year)

R.

AXE

NOV 0 8 2007

STEVEN

30. Name and aderess of person who completed cause of death (Item 23a) (Type, Print)

M. D.

32. pgistrar's Signature

7601 OSLER DRIVE TOWSON.

29c. License number

D34543

29d. Date signed (Month, Day, Year)

MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 2, 2007 ar **Physician** Powell 2:27 р м Arthur W. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist 8. Date of Birth June 2, 1931 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Hours Months Days Min. 1 XM 2 ☐ F 76 204-22-1752 Pennsylvania Director Usual Residence of Decedent buld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits o and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show
is marked other than "natural", or items 23a or 28a-f show
""" in matte event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Md. Baltimore Baldwin Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 13613 Brookline Road 21013 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔼 No Specify. Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce. A. Arthur Powell Gertrude R. Ratledge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13613 Brookline Rd. Baldwin, Md. 21013 Mrs. Barbara M. Powell/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Hilltop Service Co. 4 ☐ Donation 5 ☐ Other (Specify) 11-6-07 Towson, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Fugreral Service Licensee complication that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Head with week ALL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the attending physician and the death certificate be execu Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ASTro on toma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hask autopsy performed2 res 2 No 1∐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending Fell from chair at Home 8:00 PM 1 ☐ Yes 2 ☐ No investigation October 21,2007 2 Accident Cirector; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fter Home 13613 Brookline Road, Baldwin, MD within 24 hours at 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Vital Division

101

State Registrar 31. Date filed (Month, Day, Year) NOV 0 8 2007

29b. Signature and title of certifier



dress of person who completed cause of deat (Item 23a) (Type, Print)

Charles St. Balfs. Md 21207

w

29c. License number

29d. Date signed (Month, Day, Year)

November 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	state of Maryland		tificate of L			eg. No. 2	007	35866
	Physicia		1. Decedent's Name (First, Middle, Last)	UELL				2. Date of Dea Month	Day	Year 2 00 7	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death	NUV		nty of Death	
	Examin	er	NORTHWEST	MOSPITAL		RANDA	HLSTON	SAC	B	ALTIA	1026
	Funeral	7-	5. Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	Coun	ace (State or Foreign try)
L	Director		226 26 1781 Usual Residence of Decedent	x 89	Yrs.			DEC.6	,1917	VA.	
	/land low at		10a. State 10b. County		, Town or Lo					10	Od. Inside City Limits
	e Man la-f sh tified	ctor	MD. BALTIMO	RE C	CATON	SVILLE					1XYes 2□No
	vith the	Director	10e. Street and Number			10f. Zip Code 21228			USA	of What Coun	try?
	eath v	Funeral	1221 EOLLING RO	. Was Decedent Ever in U.S	S. 13. \	Vas Decedent of Hi f Yes, specify Cuba	ispanic Ongin? (Sp	ecify Yes or No-		Race - Americ	
130	a within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Fun	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cuba f □ Yes 2 No	Specify:	Hican, etc.)		Black, White, ecify: BLA	
15-0036	in 72 hou n "natura Medical E	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	16a. Deced (Give life. I	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work l)	ing		of Business/Inc	
7 7	filed within Hygiene. ther than "	lmo:	6	College (1-401 5+)	dom	estic				vate	nomes
g	0 m 0 %	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam Addie	e (First, Middle, Cobbs	Maiden Sui	rname)	
Maryland	d 2 should be th and Mental 7 Is marked of traumatic ev	٢	Archer Harper 19a, Informant's Name/Relationship (Type	Print)	19b Mailir	ng Address (Street			er, City or To	own, State, Zip	Code)
<u>g</u>	d 2 s th ar 7 ls trau		GWENDOLYN POWELL		1						Md.21213
Ē,	← ± h ≠		20a. Method of Disposition	20b. P	lace of Dispo emetery, crea	sition (Name of matory or other plac	ce)	Date	20c. Locati	on - City or To	wn, State
Ē	Pages nent of ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	MOVAL FROM State		MEM.PK		12,200	BA	LTO,MI).
Baltimore,	permit. Page Department of Important: If any injury of once.		21 Signature of Funeral Service Licenses	7. Merue	CA	2. Name and Addre LVIN B.	SCRUGG RESTON	ST. BA	LTO . M	IOME	213
Ţ.			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the realist cause on each line.	n. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in deathy	Due to (or as a consequence of the land)	uence of):	OBITE	ACTIVE	PHIMO	NARY	DICET	KE
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	outed and a	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
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68760	ficate physi	edical	d.				_				
Box	The law requires that the death certificate be executed at has been signed by the attending physician and $\overleftarrow{\mathcal{K}}$ bage 2 should be detached for use as the burial-transit	M/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy							I. Date of deliv	ery Day Year
	e deat the atto	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown						Month L		
P.O.	w requires that the de been signed by the should be detached		Part II. Other significant conditions conf	ributing to death but not res	ulting in the u	ınderlying cause giv	ven in Part I.	23e. Did t	obacco use	contribute to t	the cause of death?
ds,	uires n signo	d by						10	Yes 2□	No 3□ Pro	bably 4 Unknown
S	aw rec s beer 2 shou	Completed						24a. Was		24b. Were auto	opsy findings available ompletion of cause of
Ä	The law ate has page 2 s	mo:						perfo 1□ Yes	ormed? 2021 No	death?	2 No
Vita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	ospital:		Ott	nor:	ath (Check only		704 (0	
o	Physic ruthis or rall din	- 1º	1 ☐ Yes 2 No	28a. Date of Injury	28b. Time	III 3 DOA	4 □ Nursing F	lome 5 ☐ Resi 28d. Describe			Ty)
ion	nding th. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk?]Yes 2□No				
Division or Vital Records,	l or Atte after des Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, st	treet, factory, office		28f. Location (City or To	Street and I wn, State)	Number or Rui	ral Route Number,
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical Co	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my known to the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis o	owledge, dea ation and/or i	th occurred at the t nvestigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time	cause(s) a , date and p	nd manner as lace, and due	stated. to the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifier			29c. Licen	se number			signed (Month	
			1 Walnut	an M	0		53910		\sim	DV 2.	2007
•	N		39 Name and address of person who co	MD NOV	THWF	ST MOJ	IPITM,	FANDA	11570	WN.	MD
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	ع					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Nov. Josephine Cecilia Robinson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 350 Suter Road Baltimore Catonsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5-4-1935 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 3 F Days 223-40-5604 72 Director VA Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MDBaltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 350 Suter Road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Caucasian Specify þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Analyst Social Security Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Corso Florence Henderson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 348 Suter Road, Catonsville, MD 21228 Yahyaa A. Aziz/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🗡 Removal from State Holy Cross Cemetery 11-10-2007 Richmond, VA 4 ☐ onation 5 ☐ Other (Specify) ature of Funeral Service Lic 9200 Liberty Rd., Randallstown, MD 21133. A. of Balto. Co. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ORonny **Physician** YRS /Medical Due to (or as a cons quence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, cal Physician/Medi as the attending IF FEMALE: for use yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) ned by the a 9□Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, cate has been sig page 2 should b 1 ☐ Yes 2 ☐ MO 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes perform certificate 2□ No 1☐ Yes 21 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 2 No 1 Tyes ၀ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 533745 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar Dr. Kenneth Williams 1120N. Rolling Rd. Catonsville ,Md. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 0 8 2007

11-05-2007

21228

	sbach		State of Maryland / Department of F I-For State Certificate of D Registrar			, No. 200	3586
P Medical	hysicia Exami	an/	1. Decedent's Name (First, Middle, Last) Paul Theodore Rossbach, III		2. Date of Death Month October 23	Dav Year	Time of Death 1445 hrs
e***			4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death		4c. County of Death	
E.	uneral	щ.		Parkville f Under 1 Year If Under 24Hrs	. 8. Date of Birth	Baltimore Count	
	rector			Months Days Hours Min	_	Foreign	
	any	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
pue	A	٦	MD Baltimore Baltimore				Yes 2 No
Maryla	23a or 28a-f sho notified at once	Director	,	0f. Zip Code 21234	10	g. Citizen of What Countr	y?
with the	s 23a o e notifi		3016 Willowby Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	ecedent of Hispanic Origin? (S	pecify Yes or No-	USA 14. Race - America	n Indian, Black,
death	or item must b	Funeral	X Never Married 2 Married 1 Yes 2 X No	specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
rs after	ural", miner	à	or Dates:	es 2 X No specify: Usual Occupation (Give kind of	work done	Specify: wh 16b. Kind of Business/Inc	ite
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-003 within	giene her th? e Medi	dmo	12 3 Salesma		e (First, Middle, M	Vehicles	
215. be filed	rked of ent, th	Be	Paul T. Rossbach, Jr.	Marcell	a L. Ric	e	
MD 21215-0036 d 2 should be filed within 7	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumafte event, the Medical Examiner must be notified at one	은	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	ddress (Street and Number or n Lodge Ct. Un			
e, M	Health item 2 r traun	ŀ	20a. Method of Disposition 20b. Place of Disposition	n (Name of cemetery,	Date	20c. Location - City or To	
Baltimore, permit. Pages 1 ar	nent of ant: If or othe		4 Donation 5 Other Specify: Metro Crema	1,	25/07	Catonsvill	e, MD
Balti permit.	Departr Import injury		21. Signature of Funeral Service Licensee Lowell M. Lemmon 10 W	me and Address of Facility	me of Du	laney Valle	y, Inc.
	sician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	Padonia Rd.,	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
	edical miner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Alcohol, narcotic and Immediate Cause (Final disease a. Alcohol and narcotic intox	ication and cocain	e use		Death
			or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			=	
		iner	if any, leading to immediate Due to for as a consequence officause. Enter Underlying Cause				
uted	and H	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed.	ysician an burial - tr	fedical	X UNPENDED X AMENDED #23a, perME, 9873, 1 #1,23a, 27,28a-f, perME, 9	1/19/07 TT 873, 11.14.07 TT			
8760, tificate be	ng phys as the b	In/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	death 3 Ectopic pregn	ancy	23d. Date of delivery Month Da	y Y ear
Box 687	e attending phy	Physician/N	past 12 months?	(Specify)			
O. El at the d	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached for		Part II. Other significant conditions contributing to death but not resulting in the unc	erlying cause given in Part I.		bacco use contribute to the	photosmog
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al Re	rtificati tor, pag		25. Was case referred to medical	26.Place of Death (Check	only one)	2 No 1 ✓ Yes	2 No
Vita hysicie	r this ce al direc	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient			Residence 6 V Other:	Scene
n of	th. :: After e funer	ion:	27. Manner of Death 1 Natural 5 Pending Render 1 Pending	1 Ves 2 VNo	unk	ow injury occurred	
ViSiC or Atte	fter dea Director in by th	Certification:	2 Accident 3 Suicide Suicide Accident Suicide Suicide Accident Suicide	*	28f. Location (S or Town, St	treet and Number or Rura	al Route Number, City
Spital o	hours a neral I		4 Homicide determined (Specify) found in residence		3016 Willa	oughby Rd Parky	
the He	within 24 hours after To the Funeral Dire completely filled in b	Medical	293. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrer (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	d at the time, date and place, and, in my opinion, death occurred	at the time, date a	e(s) and manner as stated and place, and due to the	cause(s)
-	ĭ≅ T ⊗	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	h, Day, Year)
			Wide Hellan	O.C.M.E.		October 24, 2007	
-E	-		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn St	eet, Baltimore, MD 2120)1		
	S Regis	tate trar	31. Date filed (Month, Day, Year)				

OCME

DHMH 17 Rev 1/2001

ORIGINAL

Division or Vital Records, P.O.

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mary Louise Sipes November 2007 5:40 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Gilchrist Center Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 3/18/1932 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 1□M 2**X**F 220-30-4569 75 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 Waveland Road 21228 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Inportant: If Item 27 Is marked other i fany Injuly or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Percy Klein Britcher Mary Gonzales ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles H. Sipes (Husband) 314 Waveland Road, Catonsville, MD _21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐ Removal from State Mt. Olive UM Cemetery 11/09/07 Randallstown, MD 21133 5 Dother (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc al Service Licenses 8728 Liberty Road, Randallstown, MD 21133 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** months -Ung /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2□ No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဥ 2 ER/Outpatient 3 DOA btospice 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of gertifier 29d. Date signed (Month, Day, Year) , unb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. A. R. Ley G. Bow Lot 701 No Charles St. Balts. Md 2, 704 31. Date filed (Month, Day, Year) 32 Legistrar's Signature State NOV 0 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2,2007 8:15 P.M Albert Starzynski November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ruxton Health & Rehab Center Pikesville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 X M 2 □ F Director 216-74-2302 82 Jan3,1925 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 No Director Md. Pikesville Baltimore 10g. Citizen of What Country? 10e. Street and Number 7 Sudbrook Lane 21208 U.S.A. Funeral ould be filed within 72 hours after death Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status r than "natural", or item the Medical Examiner Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: White Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evence. Casimir Starzynski Helen Balcer Pages 1 and 2 should 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 A-Running Creek Way Bel Air, Md 21014 Frank W. Kail (nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-5-2007 Baltimore, Maryland Holy Rosary Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilityaczorowski Funeral Home, PA Robert 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) trtenoscientic cardiovascular years **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusite (or as a consequence or): Examine TARZYNSKI MBOAT 4/2/07 Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a Was an 1 Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient Other: Certification: To 1 🔲 Yes 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred at the time. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 8 O VON 2007

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565N. Charles Street Sufe 209/Bacto MD 21204

07-08580 Jianyia Thompson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nyia Thompson		State of	Maryland / Departme	ent of Health and ate of Death	d Mental Hygie	Reg. No.	20	07 3587
Physician	Pagis		Octanoa		2. 🖸	ate of Death		3. Time of Death O 0942 hrs
/Physician Examiner اعط		Jeanvia	hone	300	Location of Death	ovember 4, 2	007 c. County of Death	00.12.1110
		Facility Name (if not institution, give st University Hospital	reet and number)	Baltimore			\mathcal{N}	0
Funeral		ocial Security Number 6. Sex	7. Age (In yrs. last birth			Date of Birth (MM	VDD/YYYY) 9. Birth Foreign	1 1 1 2
Director	2	18-77-0590 10M	2VF Na	Yrs. Manths Day	/s Hours Initial	anuay 2'	1,20011 COL	intry) N
P)		al Residence of Decedent State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
P Ge on	W	lary had I	a	Baltimo	re		- Calle at Cour	1 Yes 2 No
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hyggiene. 27 is marked other than "natural", or items 23a or 28a-f show any matic event, the Medical Examiner must be notified at once. TO BE Commissed by Furneral Director	10e	Stree and Number	Disable Ch	10f. Zip Code	21217	10g. C	itizen of What Cour	in y:
ith the 23a or notifie		2003 No.	12. Was Decedent Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Speci an, Mexican, Puerto Ric	fy Yes or No-	14. Race - Ameri White, etc.	can Indian, Black,
r death with or items 23 must be no Funeral	1	Never Married 2 Married	Armed Forces? 1 Yes 2 No			can, cto.)	Specify: B	ack
safter d	_ 3	Widowed 4 Divorced to Divorced	f Yes, Give Year or Dates: (highest grade completed) 16a.	1 Yes 2 N Decedent's Usual Occup	ation (Give kind of wor	k done 16b	. Kind of Business/	Industry
"natura		5. Decedent's Education (Specify only Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working lif	fe. DO NOT use retired)	NIL	7
5-0036 led within 72 hours Hygiene. I other than "natu the Medical Exan		0	0	Vever	18.Mother's Name (F	irst, Middle, Maid	en Surname)	
215-0 be filed w ntal Hygiv rked other ent, the f		Father's Name (First, Middle, Last)	Thompso	n	Miche	lle L	le	
ages 1 and 2 should be filed within 72 ages 1 and 2 should be filed within 72 and fleath and Mental Hygiene. It: If item 27 is marked other than the international covent, the Medical andre transmette event, the Medical	19	a. Informant's Name/Relationship (Ty	pe, Print) (Mother) 19	9b. Mailing Address (Str	eet and Number or Rui	ral Route Number, St. Balto	D. Mtl. 2121	7 Code)
MD nd 2 sho alth and sm 27 is	20	a. Method of Disposition	Le 20b. Place	of Disposition (Name of	cemetery,	Date 20	c. Location - City o	r Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to		Burial 2 Cremation 3	Removal from State	atory or other place)	tera 11/12	2 2007 1	Lansd	Owne
Baltimo permit. Pages Department o Important: injury or oth	21	Donation 5 Other Specify: Signature of Funeral Service Ligens		N me and Addr	ess of lility	ineval 1	tomes P. A	21216
		ta. Part I. Enter the disease, or compl	inations that cause, the death. Do	not enter the mode of dying	A A Cable of	N/# 3 34 U	IVI O	Approximate Interval Between Onset and
Physician 'edical	- 1	failure. List only one cause on each	Sudden unexplained					Death
aminer	lr o	nmediate Cause (Final disease a. condition resulting in death)	Due to (or as a consequence of):					
		equentially list conditions, b. any, leading to immediate	Due to (or as a consequence of):					
	틾	ause. Enter Underlying Cause Disease or injury that initiated	Due to (or as a consequence of):					
e executed sian and rial - transit	<u> </u>	vents resulting in death) Last d.		_675 11 0 07	v.t.			+
be executed sician and urial - transit	dical	X UNPENDED	#23a.27.2	g 873 11-8-07 8a-f . perME.g87	4. 12/ <u>17</u> 07 TT		23d. Date of deliv	rery
	₩	FEMALE: 8b. Was decedent pregnant in the	23c. If yes, outcome of pregnant	2 Fetal death	3 Ectopic pregnar	псу	Month	Day Year
ox 68 th certi	Physician/M	past 12 months? Yes 2 ✓ No 9 Unknowr	Pregnant at time of death	5 Other (Specify)			9)	33
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be it as fler death. "All Director: After this certificate has been signed by the attending physicilled in by the funeral director, page 2 should be detached for use as the buri	Phy	art II. Other significant conditions		Iting in the underlying cau	use given in Part I.			to the cause of death? Probably 4 Unknown
P.C. res that signed be deta	d by					24a. Was ar	24b. Were	autopsy findings available
ords v requi	plete					autopsy perform	y prior ned? death	
RecC The lav	Completed			26.1	Place of Death (Check	1 ✓ Yes 2 only one)	No 1 ✓	Yes 2 No
	Be		Hospital: 1 Inpatient 2 🗸 EF		Other:	ng Home 5 F		ther:
of Viting Physic	1:1	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)		: Injury at Work?		ow injury occurred	
Sion (Attendin r death. Py the fu	atior	Natural 5 Pending Accident Investiga	End 11/4/2007 I	Fnd 6.00 am l	Yes 2 X No	unk 28f. Location (S	treet and Number o	r Rural Route Number, City
Divisior pital or Attenct ours after death teral Director: filled in by the	Certification:	3 Suicide 6 X Could no determin	ed (Specify) found a	at residence			ulaski St.	Baltimore, MD
	9 	4 Homicide 29a. Certifier 1 Certifying Physi (Check only	cian: To the best of my knowledge		me, date and place, and	d due to the cause	e(s) and manner as	stated. to the cause(s)
To the Hos within 24 h To the Fur completely	ledical		er on the basis of examination and and manner stated.		icense number		29d. Date signed	(Month, Day, Year)
	ž	29b. Signature and title of certifier	1		O.C.M.E.		November 5,	2007
OK OK		30. Name and address of person vin	o completed cause of death (Item 2	23a)		MD 04004	<u> </u>	
OCME		Mary G. Ripple MD. D	eputy Chief Medical Exam	iner 111 Penn 5	treet, Baltimore, I	VID 21201		
S Regis	tate trar	31. Date filed (Month, Day, Year)	32 Gistrar's Signature	Shorts?				
DHMH 17 Rev 1/2				ORIGINAL				

			State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene Registrar / Certificate of Death Reg. N. 2007 35873
	Physici	ian	1. Decedent's Name (First, Middle, Last) ELLIOT THOMAS WILLIS 2. Date of Death Month Nov. 2, 2007 10:39A M
	/Medio Examir		4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital 4b. City, Town, or Location of Death Takoma Park 4c. County of Death P.G.
	Funeral Director		5. Social Security Number 5. Social Security Number 5. Social Security Number 7. Age (In yrs. last birthday) 43 Yrs. 15. Under 1 Year If Under 24 Hrs. Months Days Hours Min. 15. Social Security Number 16. Sex
	the Maryland 28e-f show	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits D.C. N/A Washington 10g. Citizen of What Country?
	th with t	al Dir	2016 Perry Street, N.E. 20018 U.S.A.
9800	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "haturel", or Items 23e or 28e-f show or other traumetic event, the Medical Examinar must be notified at	d by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Townsever Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 Yes, Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify:
21215-0036	d within 72 h jiene. ir than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3 16a. Decedent's Usual Occupation (Give kind of work done during most of working Eliectronic Industrial Control Mechanic Leader 16b. Kind of Business/Industry Fed. Gov 't
	12 should be filed within h and Mental Hygiene. 7 is marked other than " traumetic event, the Med	To Be C	17. Father's Name (First, Middle, Last) William C. Willis 18. Mother's Name (First, Middle, Maiden Surmame) Fairley L. Brumfield
Maryland	id 2 shou th and M 27 is mar traumet		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Willis/Father 2016 Perry St. NE D.C. 20018
Baltimore,	permit. Pages 1 and 2. Department of Health ar Important: if Item 27 is any injury or other trau		20a. Method of Disposition 1 Removal from State 1 Date 20c. Location - City or Town, State
Balt	permit. Departr Imports any inji		21. Signatu of Funeral Service License 22. Name and Address of Facility Hackett's Funeral Chapel, Inc. 814 Upshur Street, N.W.
8760,	American and wasician and hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause (Firef Luciser) as or injury that initiated events resulting in death) Last Shock, or heart failure. List only one cause on each line. Cardiac arts Due to (or as a consequence off) Due to (or as a consequence off) Due to (or as a consequence off) Due to (or as a consequence off) Due to (or as a consequence off) Due to (or as a consequence off): Due to (or as a consequence off): Due to (or as a consequence off):
O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
Vital Records, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chicked Vitaria Diz defice 1 1 Yes 2 No 3 Probably 4 Unknown
II Rec	icien: The law certificate has bector, page 2 s	Completed	24a. Was an autopsy performed? 1 Yes 2 XNo 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 XNo 1 Yes 2 No
of Vita	Physicien: r this certifica ral director, I	To Be	25. Was case referred to medical examiner? 1
Division of	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending investigation 3 Suicide 4 Homicide Suicide 4 Homicide Suicide 1 Homicide Suicide 5 Pending investigation 5 Pending investigation 1 Nay Year) Suicide 1 Natural Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	e Hospita 24 hours e Funere letely fille	Medical C	29a. Certifier (Check only one) 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To th Withir To th compl	Me	29b. Signature and title of certifier D26972 29c. License number D26972 Nov. 7, 2007
500	10		30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Ellen D. Finkelman, M.D. 6525 Belcrest Rd. S150 Hyattsville, Md.
T-1	Sta Registi	. 6	31. Date filed (Month, Day, Year) 11-7-07 NOV 0 32. Registrar's Signature

			1 - For State Registrar	(Certificate of D	Death	Reg. N	No.	
П			Decedent's Name (First, Middle, La	st) A	0.11	2.	Date of Death Month	ay Year	3. Time of Death
П	Physici /Medic		Giada Girano	i Anna Marie A	tllen		- 1	2 2007	5:12 PM
	Examin		4a. Fecility Name (If not institution, give	1 00.	4b. City, Town, or	Location of Death	4	4c. County of Death	, 0
			Anne Hrundel	Me dical Center	Anne	Pulis		Hnne Hr	ndel
	Funeral Director			· Clarated	rs. If Under 1 Year Months Days	Hours Min. 8.	Date of Birth (Month, Day, Yea i O - 9 -		place (State or Foreign htry)
	and **		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town	or Location			1	0d. Inside City Limits
	se-f sho	Director	ms Prince	George's Bor	w:e		1.0-	200	1 ∰Yes 2 □ No
	23a or 2		10e. Street and Number 5223 Mari	es Retreat D	10f. Zip Code	20		Citizen of What Cour	
36	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It amd Mental Hygiene. It is marked other than "natural", or iteme 23s or 28s-f show traumatic event, It a Medical Examinar must be notified at	by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [▼] No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☒ No	spanic Origin? (Specifin, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Americ Black, White,	
ğ	2 hou	ted	15. Decedent's E	ducation 16a.	Decedent's Usual Occupa	tion	16b.	Kind of Business/In	dustry
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	the Head		20a. Method of Disposition	20b. Place of	Disposition (Name of c, crematory or other place	Dat	e 20c.	Location - City or To	own, State
OE.			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	_Removal from State	Crematory	10/19/	2007 Ba	ltimore,	MD
Baltimore,	permit. Page Department Important: if any injury o		21. Signature of Funeral Service Lice		22. Name and Address 12 Ridgely		esty Funapolis,		, P.A.
			23a Part Enter the disease or com	polications that caused the death. Do no				TID 21401	Approximate
П			shock, or heart failure. List only Immediate Cause (Final	plications that caused the death. Do not one cause on each line.	,	,	1		Interval Between Onset and Death
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68760	ate b shysic the b	Medical		d					
	± 00 €		IF FEMALE:	23c. If yes, outcome of pregnancy				004 Data 4445	
Вох	that the death certificate be executed ed by the attending physician and detached for use as the burial-transi	Physician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv Month	ery Day Year
o.		ysic	1 ∐ Yes 2 Ø No 9 ☐ Unknown	9 Unknown	3 Cale (specify)				
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rds	quires n sign	d by					1 ☐ Yes	2 1 No 3 Pro	babiy 4 □Unknown
Ö	sw requir s been si should	ompleted					24a. Was an	24b. Were aut	opsy findings available
Re	The lay	E					autopsy performed 1 ☐ Yes 2 ☑	? death?	empletion of cause of
ital		Se C	25. Was case referred to medical examiner?			26. Place of Death (
>	g s	ToB	1 ☐ Yes 2 🏋 No	Hospital: 1 Ninpatient 2 ☐ ER/Out	patient 3 DOA Othe	r: 4 ☐ Nursing Home	5 🗌 Residence	6 ☐Other (Speci	fy)
0			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. T (Month, Day Year) In	ime of 28c. Injury jury Work	at 28	d. Describe how in	njury occurred	
sio	Attanding r death. ector: Atter	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not the			es 2□No			
Division of Vital Records,	i or Attanatter deatl Director:	ertification;	4 Homicide determined		m, street, factory, office	28	f. Location (Street City or Town, St	and Number or Rur ate)	ai Houte Number,
	To the Hospital or At within 24 hours atter of To the Funeral Direct completely tilled in by	edical C	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my knowledge, miner: On the basis of examination and and manner stated.	death occurred at the tim Vor investigation, in my op	e, date and place, an einion, death occurred	d due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	The state of the s	29c. License	number	29d.	Date signed (Month,	Day, Year)
	-		& Summer of	La - inolland	, H 42	733	Cons	tohoc 1	4. 2007
	, 0		30. Name and address of person who	completed cause of death (Item 23a) (, ,	10
-	200		Suzame Kind	leis DU AAHC	2001 Med	head Thu	y. An	apdis, M	d 21401
	Sta		31. Date filed (Month, Day, Year) OCT 2 3 20	32 Aegistral's Signature	house.			1	
	Registr	ar	001 20 20	JUI JAMES JA	More				

DHMH 17 Rev 1/2001

Certification: To Be

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Leath 1 Inpatient 2 ER/Outpatient XXDOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? **XX**Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier XX CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature an

31. Date filed (Month, Day, Year) 0CT 2 3 2007

title of cert 29c. License number 29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

132 Holiday Court Suite 201 Annapolis, Maryland 21401 Matthew J. Malta

State Registrar

Medical

within 24 hours after death.

To the Funeral Director; /
completely filled in by the f

To the Hospital

			1 - For State O	r Maryland	/ Depa <i>Cer</i>	rtment of H tificate of L	ealth and IV Death	Tental Hyg	eg. No. 200	7 35876
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Lelia June Br. ce					2. Date of Dear Month 10/18	Day Yea	3. Time of Death 02:04P M
	Examin		4a. Facility Name (If not institution, give street and nur			4b. City, Town, or	Location of Death		4c. County of D	
	3 T. I	Ø	6214 Tolchester Rd.	7 A (4 6 3 46 4	Rock Ha	11 If Under 24 Hrs.	O Data of Birth	Ker	
ď	Funeral Director		5. Social Security Number 214-32-0513 Cysual Residence of Decedent	7. Age (In yrs. las	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 6/24/	Year)	Birthplace (State or Foreign Country) PA
	/land ow at		10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fleem 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	MD Kent]	Rock H	lall				1 XYes 2 No
		Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
		eral	6214 Tolchester Rd.	deat Francia II C	10.14		661		USA	merican Indian.
020	urs after de al', or item xaminer r	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Deccarried 1 □ Yes II Yes, Giryear, or Deccarried 1 □ Year or Deccarried 1	2 X No ′e		Vas Decedent of Hi Yes, specify Cuba ☐ Yes ② No	spanic Origin? (Spin, Mexican, Puerto	Rican, etc.)		/hite, etc.
5	72 ho	sted	15. Decedent's Education (Specify only highest grade completed)	I	16a. Deced	ent's Usual Occupa kind of work done of ONOT use retired	ation Juring most of work	ing	16b. Kind of Busine	ess/Industry
7	vithin ine.	Completed	Elementary/Secondary (0-12) College (1					1	D 1.	
7	filed v Hygie other t		17. Father's Name (<i>First, Middle, Last</i>)	1	Brancr	Manag er	18. Mother's Name		Banking Maiden Surname)	
<u> </u>	lid be lental ked o lc eve	To Be	Emerson T. Dykes				Loren	na Noel	ĺ	
S S	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailing	g Address (Street &	and Number or Run	al Route Number	r, City or Town, Stat	re, Zip Code)
	and 2 ealth n 27 i		David Kirwan/Son		5782	Downey A	ve. Rock			
2	ges 1 It of H If iter or oth		20a. Method of Disposition 1 ဩ Burial 2 ☐ Cremation 3 ☐ Removal from			ition (Name of natory or other place			20c. Location - City	
	iit. Pa artmer artant: njury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	St. I		Cemeter	•		Chesterto	own, MD 1 & Newnam
0	Departi Departi Import any it		The signature of which allowed					-	MD 21620	
F	Physician /Medical		23 art1. Enter the disease, or complications that of shock, or heart failure. List only one cause on elimmediate Cause (Final disease or condition resulting in death)	ach line.	chan	r the mode of dying		or respiratory arr	est,	Approximate Interval Between Onset and Death
	Examiner			or as a conseque	rice oi).	U				
	p . !.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	or as a conseque	nce of):					
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	or as a conseque	nce of):					
5	rificate be executed g physician and as the burial-transit	al E								
9	tificate g phy as the	ledical	d							
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?	come pf pregnand irth 2 ☐ Fetal d ant at time of dea own	eath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
100	quires that n signed by	by	Part II. Other significant conditions contributing to de	eath but not resulti	ng in the un	derlying cause give	en în Part I.	23e. Did tol		e to the cause of death?] Probably 4 ☐Unknown
200	The law red te has bee age 2 shou	Completed				_		24a. Was a autops perform	sy prior med? deat	e autopsy findings available to completion of cause of h?
	sian: ertifica ctor. p	BeC	25. Was case referred to medical examiner?				26. Place of Deat		~	2010
	hysic this ce al dire	To	1 ☐ Yes 2 No Hospital: 1 ☐	npatient 2 EF			4 LI Nursing Ho		ence 6 Other (S	Specify)
	Jing P	ion:	Tending.	of Injury 2: th, Day Year)	8b. Time of Injury	28c. Injury Work	rat :? Yes 2 □ No	28d. Describe he	ow injury occurred	
NO INCIDIO	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place buildi	of injury - At homong, etc. (Specify)	e, farm, stre			28f. Location (Si City or Town		r Rural Route Number,
	e Hospita 24 hours e Funeral letely filled	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the b and man	best of my knowle asis of examinationer stated.	edge, death n and/or inv	occurred at the timestigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, c	ause(s) and manne late and place, and	r as stated. due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. License			9d. Date signed (M	
	1 4		Intoo mo	?		Dos	17036	-Md,	10/19/01	7
	16		30. Name and address of person who completed cause Susuk 1655 m.D. 5/6	Washing	ton A	oe Ole	stritom	rud a	10/19/01	
	Sta Registr		31. Date filed (Month, DayOCT 2 2 2007)	egistra s Signatur	re da	And .			, de	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) October 24, 2007 11:36 Å M **Physician** Mary Jean Brubaker /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Leonardtown 22680 Cedar Lane Court, Apt. 1430 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or For Country) | Sept. 8, 1920 | Pennsylvania Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F 87 Director 175-22-4051 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a State nd 2 should be filed within 72 hours after death with the Maryla. Ith and Mental Hyglene. 22 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Y□Yes 2□No Leonardtown Directo Maryland St. Mary's 10g. Citizen of What Country? 10e. Street and Number USA 20650 22680 Cedar Lane Court, Apt. 1430 Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify. White Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Bushko George Hrenyo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17935 River Shore Drive, Tall Timbers, MD 20690 Jeanine Grubb - Daughter f Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 a
Department of Her
Important: If item
any Injury or othe 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Waldorf, MD **Huntt Crematory** 10-26-07 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility M00053 3035 Old Washington Road You Waldorf, MD 20601 Huntt Funeral Home 4. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death acute Immediate Cause (Final possible **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Hyperlipidemia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trar Due to (or as a consequence of): 68760, Physician/Medical ending physic r use as the b IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 2 5 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident neral Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

Avani D. Shah, MD, 22650 Cedar Lane Ct., Leonardtown, MD 20650

31. Date filed (Month, Day, Year) OCT 2 6

29b. Signature and title of certifier

29c. License number

47066

29d. Date signed (Month, Day, Year)

10.24.07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:45 P October 16 2007 Fern Elizabeth Bishop /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 1 1 Director 726-12-1248 79 Feb. 3, 1928 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 X Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 845 Waterford Drive 21702 United States Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: ss 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Towles ျှ Fern Carew 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Anthony / Daughter 1003 Dulaney Mill Drive Frederick, Maryland 21702 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State jo **1** permit. Pages Department of Important: If It any injury or conce. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, Maryland 10/22/2007 21. Sign wife of Funeral Service Licens 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 Part1. Enter the disease, or complications that shock, or heart failure List only one cause on the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nec /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed the burial-tran Due to (or as a consequence of) Box 68760 physician Physician/Medical as ate has been signed by the attending page 2 should be detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 4 1 ☐ Yes 2□ No 1∐ Yes 2 Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🖺 Yes 1 Inpatient 2 ER/Outpatient ဥ 3□ D0A 27. Manner of Death Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Attending (Month, Day Year) Injury 5 Pending o the Hospital or Attendir ithin 24 hours after death. o the Funeral Director: At ompletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 ☐ Medical Ex On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D62471

DHMH 17 Rev 1/2001

State

Registrar

400 W. Seventh Street Frederick, Maryland 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

Abbas, MD

OCT 2 6

Ghulam 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Data-filed (Month, Day, Ye

Yai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M-D.

12821

29c. License number

Hill Are, Hagerstown,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 Detober nomas /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner EASTON HOSPITAL THE MEMORIAL ALBO 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 1 M 2 □ F Days Months 215-26-393 Usual Residence of Decedent Director Maryland Feb. 26. 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Easton Director Talbo Pages 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number 10g. Citizen of What Country? 03 OW USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ID Yes 2 No 1952.
If Yes, Give Year or Dates: 1956 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur Self-employed 10 Department of Health and Mental Hygi Important: If item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SSie Blanche Anderson ဂ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Meadow Easton, Maryland 21601
20c. Location - City or Town, State Drive hristina 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Veterans Cemetery Hurlock, Maryland injury 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Facility Home 21. Signeture of Funeral Service Licensee any Cambridge, MD. 2/6/3 510 Washington St 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Seps s

Due to (or as a ronsequence of): 24 hours Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the I IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an lon 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural Iniurv 1 ☐ Yes 2 ☐ No death. 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending Physiclan: within 24 hours after death To the Funeral Director:

> State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Mary S. DeSh 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DeShields, M.D.

Easton,

MD 21601

219 S. Washington St.,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ruth Jean Buell October 20, 2007 5:17A, M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George's Laurel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth April 12,1923 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min New York 086~18~7874 84 Director Usual Residence of Decedent 10c. City, Town or Location 28a-f show notified at 10a State 10b. County 10d. Inside City Limits Maryland Prince George's Beltsville 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Manfal Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or; any injury or other traumatic event, the Medical Examiner must be none. 4612 Olympia Avenue 20705 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married I ∏Yes 2 ☐ f Yes, Give Year or Dates: 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify Specify: Completed by 3 ☐ Widowed 4 Noivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5†)-4 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Harold Van Nov Kathleen Mary Finlayson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4316 Knott Street Beltsville, Maryland 20705 Roberta B. Deegan -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 10/21/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 mala 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebral Thrombosis **Physician** Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ cate has been sig , page 2 should b 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? Yes 2 X No this certificate I 1∐ Yes M□ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28c. Injury at Work? Certification: After 1 XNatural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely

State Registrar

29b. Signature

31. Date filed (Month Cor, Year) 2007

32. Resistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William A. Warren, M.D. 321 Prince George Street Laurel, Maryland 20707

29d. Date signed (Month, Day, Year) October 20, 2007

State of Maryland / Department of Health and Mental Hygiene 35882 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 11:38a ^M Dolores Mary Bovle October 21, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F Director 224-32-0471 87 Dec. 6, 1919 North Dakota Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits f show or than "natural", or items 23a or 28a-f show the Mudical Examiner must be notified at 1 ☐ Yes 2 ▼ No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15421 Bassett Lane 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 2 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home i 2 should be filed v n and Mental Hygie ie marked other t other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bert Frederick McDowell Lillian Elvira Madison 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If Item 27 is George T. Boyle, Sr./Husband 15421 Bassett Lane, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oct. 25, 5 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 21. Signatur of Fun ral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W, Silver Spring, Techard I Holy MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction 8 days /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Years Sequenticly list and tensificany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed **burial-transit** and Due to (or as a consequence of): Box 68760, physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 0 the detached á ۵. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Acute on Chronic Renal Failure, Atrial Fibrillation, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Branch Pulmonary Artery Rupture, Myelodysplasia, this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Peripheral Vascular Disease, COPD 1 Yes : After this certific funeral director, 25. Was case reterred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the f 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 132 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29b. Signature and title of certifier 29c. License number D64279 29d. Date signed (Month, Day, Year) October 23, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael S. Chen, MD 15225 Shady Grove Road, #201, Rockville, MD 20850 32. Raistrar's Signature 31. Date liled (Month State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend, i tem 29d per doc 2873 11-13-07 vt.

Amend#23a&b Per Phy& 29d Per Phy 6373 11/09/07 JH 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 23, 2007 10:26 P.M OCTOBER ESTELLE BOSSIN G. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9707 Old Georgetown Road, # 1419 Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** F Months Days New Jersey Director 24, 1916 90 Oct. 142-09-5148 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 1 X Yes 2 □ No Directo Bethesda Maryland | Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20814 U. S. A. 9707 Old Georgetown Road, # 1419 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after of Hygiene.
Hygiene.
wther than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3 ₩idowed 4 Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 2 Years Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rebecca Silverstein Louis Goldstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8808 Mayberry Court, Potomac, Maryland 20854 Carol B. Striner - Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State Falls Church, Virginia 10/26/2007 King David Mem. Gdns 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 21. Signature of Funeral Service Licensee 20852 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimer's Disease **Physician** Bladder Cancer /Medical Due to (or as a consequence of): Examiner Alzheimer's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Decubitus Ulcers 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Osteoarthritis 24a. Was an autopsy performed? Yes 2 ANo 2 No Cerebrovascular Disease 1□ Yes 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2√∑ No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 [XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and file of certifier 29d. Date signed (Month, Day, Year) 11-5-07 D20367 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) 1396 Piccard Drive, Rockville, Maryland 20850 Joe1 Kalman 31. Date filed (Month State 5 Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. ELAING $\beta \mathcal{E}_N \mathcal{O} \mathcal{E} \mathcal{E} \mathcal{L} \mathcal{A}_\mathcal{I} \mathcal{N} \mathcal{C}$ Baltimore, Maryland 21215-0036 Physician /Medical Examiner

Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

		For State Registrar	State of	Marylan	d / Depa <i>Cer</i>	rtment of F	lealth and Death	Mental Hy	giene 2 (07 3588	84	
Physicia		Decedent's Name (First, Middle Elaine France						2. Date of De Month	eath Day	Year 2007 8,028	h 2 _М	
/Medic		4a. Facility Name (If not institution		per)		4b. City, Town, o	r Location of Dea		4c. County		111	
LAGIIIII	CI	Doctors Commu	nity Hospi	tal		Lanha				George's		
uneral irector		5. Social Security Number 220–46–3438	6. Sex 7 1 ☐ M 23€ F	. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Da	th ay, Year) 9, 1961	9. Birthplace (State or Fore Country) Washington,		
M		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limi		
r 28a-f sho notified a	Director	Maryland 10e. Street and Number	Prince Ge	orge's		College 10f. Zip Code	Park		10g. Citizen of V	1 ☐ Yes 2 No Citizen of What Country?		
23a o ist be	alD	7313 Baylor	Avenue			20740)		USA	A		
Depotation or result and worlds raygener. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status M3Never Married 2☐ Mar 3☐ Widowed 4☐ Divorced	If Yes, Give	es? E x No	i i	Vas Decedent of H f Yes, specify Cuba □ Yes 2 1 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Blac	e - American Indian, ck, White, etc. :: White		
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27 Is mar	-											
int: If item		20a. Method of Disposition 1		oto C	emetery, cren	sition (Name of natory or other place Peace Ch	urch	٠ ا		City or Town, State Pennsylvania		
Importa any inju once.		21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901										
rsician ledical		23a. Part1. Exter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Myo	cardinas a consequ	n. Do not ente					Approximate Interval Between Onset and Death		
and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):										
physician and s the burial-transit	dical											
y the attending p iched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Fetal nt at time of de	Ideath 3□	Ectopic pregnancy Other (specify)	у	1	te of delivery nth Day Year			
an signed build be deta	by	Part II. Other significant condition	ons contributing to dea	th but not resu	ulting in the ur	derlying cause giv	en in Part I.	23e. Did 1		ribute to the cause of death? 3 ☐ Probably 4 ☑ Onknow		
To the Funeral Director. After this certificate has been signed by the i completely filled in by the funeral director, page 2 should be detached	Completed							24a. Was auto perfo 1∐ Yes	psy prmed?	Were autopsy findings availated by the completion of cause of death? I □Yes 2□ No	bie of	
certific rector,	Be	25. Was case referred to medica examiner?	Hospital:		/	Oth	or.	ath (Check only				
After this funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date of (Month,		28b. Time of Injury	28c. Injur Wor	4 LI Nursing	Home 5 Resi	dence 6 □Oth how injury occurr			
al Director	Certification:	3 Suicide 6 Could determ	ined Zoe. Place 0	f injury - At ho g, etc. <i>(Specif</i> y		eet, factory, office		28f. Location (City or To		er or Rural Route Number,		
the Funera	Medical (one)	ng Physician: To the b Examiner: On the bas and manne	is of examinat	wledge, death tion and/or inv	estigation, in my c	opinion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)		
0	Σ	29b. Signature and title of Certifie	in mi	0		29c. Licens				d (Month, Day, Year) - 23, 2007		
Sta	to.	James SI	who completed cause	of death (Item	1105	ortal 8	3118 Go	od Luck	Rd. La	- 23,2007 unham, MD 20	706	
Registra 7 Bev 1/20	ar	31. Date filed (Month Pay Year)	2007	ال معدي	BY A	sel.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Regist DHMH 17 Rev 1/200

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10/21/2007 **Physician** Emma Kemnitz Canfield 7:45 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ginger Cove Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 200 Days Hours 0170771909 98 378-60-9983 MT Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3309 River Crescent DR. 21401 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Nidowed 4 Divorced "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Kemnitz Ottilie Seger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 187 Severn Way Susan Canfield Daughter Arnold, MD 21012 permit. Pages 1 ar Department of Hes Important: If item any injury or othe once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory 10/23/2007 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Furn ral Service Licenses 6 at 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 01 NEN /Medical Doe to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mont 3 Ectopic pregnancy Month 5 Other (specify) been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an ate has bage 2 s autopsy perform or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes 211 No 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death. neral Director; A filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifler Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month,

Day, Year)

OCT 2 3 2007

		_	For State	State of Maryland	/ Depa	rtment of H	ealth and M	lental Hy	giene 2	007	35886
			Registrar	41	Cer	unicate of t	Jeani	2. Date of Dea	Reg. No.		3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, Las		,	Jantoo		Month	Day	Year	2.33 AM
الله الاطالية	/Medic	al	Lucille 4a. Facility Name (If not institution, give	Cordilla		Contee 4b. City. Town, or	Location of Death	OCTOS.	4c. Coun	ty of Death	
	Examin	er				_			Princ	ce Ge	orges
			Doctors Memoria 5. Social Security Number 6. Se		st birthday)	Lanham If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da	h		lace (State or Foreign
	Funeral Director		216-38-5642	^{□ M 2} XF 86	Yrs.	Months Days	Hours Min.	03/20			yland
	D		Usual Residence of Decedent		Town or Lo	cation					0d. Inside City Limits
	anylar show d at	_	10a. State 10b. Counfy								1 XYes 2 □ No
	Ba-f s	5	Maryland Prince	Georges Upp	er M	arlboro 10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	with the	ä	10e. Street and Number			207	7.2		USA		•
	s 23 nust	eral	12114 Feno Road	12. Was Decedent Ever in U.S.	. 13.		I Z lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		ace - Americ	
20	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene item 27 is marked other than "natural"; or items 23a or 28a-f show item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Directo	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	lf Yes, specify Cuba 1 □ Yes 2🌠 No	an', Mexican', Puerto Specify:	Rican, etc.)		lack, White, cify: Bla	
2-003a	hour tural		15. Decedent's Ec		16a. Dece	dent's Usual Occup	ation		16b. Kind of	Business/In	dustry
Ċ	in 72 n "na Nedic	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give life.	kind of work done DO NOT use retired	during most of world)		Prince		
7	y within giene. r than " the Mec	E	Elementary/Secondary (0-12) 1 2	College (1-401 34)	Cafet	eria As	sistant		Schoo.	1 Boa	ırd
2	e filed within al Hygiene. I other than ' vent, the Me	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle	Maiden Surn		
<u>a</u>	Suld be Mental arked o	10	Richard	Jo	ohnsc		Irene				mstrong
Mar	d 2 should be the and Mental 7 is marked of traumatic evental contracts of the contracts of the contracts of the contracts of the contracts of the contracts of the contracts of the contracts of the contracts of the contracts of the contracts of the contracts of the contracts of the contracts of the contracts of the contracts of the contract of the contracts of the contract of the		19a. Informant's Name/Relationship (19b. Maili	A Deciment	and Number or Ru	ral Route Numb	er, City or Tow Maryl Ipper	n, State, Zig .and .Mar 1	20772 boro
<u>ရ</u>	of Health item 27 other tr		Geneva Butler/ 20a. Method of Disposition	20b. Pla	ace of Dispo	osition (Name of matory or other pla	e Charle	Date	20c. Location	n - City or i	own, State
<u></u>	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State		ham-Mye:	1	30/07	Inner		yland boro.
aitimor	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Licer		2	2. Name and Addre	ess of Facility Ad	ams Fu	neral	Home	PA
ñ	any any		Floy &	191	1 20	605 Aqu	asco Rd	. Agua	sco, Ma	aryla	nd 20608
			23a. Part1. Enter the disease, or consched, or heart failure. List only	plications that caused the death. one cause on each line.	Do not en	ter the mode of dyi	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Respe	rali	ary -					
*	/Medical		resulting in death)	Due to (or as a consequence	ence of):		failure	7			
	Examiner	L	Sequentially list conditions,	b. Due to (or as a consequence	cue	hear	of few	(we			
i)	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	So 4-3	I Q		,				
_	and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a consequence	ence of):						
8760	cate be executed oblysician and the burial-transit	dical E		d							
68/	ficate physis the	edic	0.5	- u							
Box	death certific attending pl	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnar		□Ectopic pregnanc	v			Date of deliv	
	death e atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de		Other (specify)				Month	Day Year
<u>Р</u>	w requires that the debeen signed by the should be detached	hys	9 Unknown				to Post I	220 Did	tahaasa usa s	ontribute to	the cause of death?
	es the gned be de	by	Part II. Other significant conditions	contributing to death but not resu	Iting in the	underlying cause gi	ven in Part I.		Yes 2□M	,	obably 4 □Unknown
p	equir en si ould b		- Jucustara	Reguirira	win	un	4	, —			
Vital Records,	B S C1	Completed		fordin	over	y sy	serlense	auti	opsy ormed?	4b. Were au prior to c death?	topsy findings available ompletion of cause of
<u>~</u>	: The	S						1□ Yes	2 No	1 ☐ Yes	2 No
<u> </u>	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital: 1 Impatient 2 I	EB/Outpatio	ent 3 DOA Ot	26. Place of De	ath <i>(Check only</i> Home 5□Res		Other (Spec	(h)
ō	Phys r this ral dir	. To	1 Yes 2 No	28a. Date of Injury	28b. Time				how injury oc		,,,,,
on	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		ork? ∐Yes 2∐No				
Division or	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined		me, farm, s	treet, factory, office)	28f. Location City or To	(Street and No own, State)	umber or Ru	ıral Route Number,
Ω	oltal o urs aft eral Di			hysician: To the best of my know	wlodan de	ath occurred at the	time date and place	e, and due to th	e cause(s) and	d manner as	stated.
	Hospital or A: 24 hours after of Funeral Directely filled in by	edical	29a. Certifier 11 Certifying P (Check only one) 2 Medical Exa	miner: On the basis of examinal and manner stated.	tion and/or	investigation, in my	opinion, death occ	curred at the time	e, date and pla	ace, and due	to the cause(s)
	To the I within 2 To the I complet	Mec	29b. Signature and title of certifier				nse number			_	h, Day, Year)
	F>F0		Makey 8	loster mir		Do	50514		10/2	2/0	
(30. Name and address of person who	completed cause of death (Item	23a) (Type	e, Print)				,	
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DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Virginia Alderman Davis 10/19/2007 5:30 ath /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Knollwood Manor Millersville Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) 5/4/1920 1 M 2 F 87 Virginia 226-16-6437 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1318 Wickell Rd. 21113 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 25 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2EXNo Saltimore, Maryland 21215-0036 1 ☐ Yes 200No Specify: White þ 3€Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meat Department Clerk Grocery 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Alderman Lillie Handcock ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Davis III Son 1318 Wickell Rd. Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md Veterans Cemetery 10/23/2007 Crownsville, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of June al Service Lice Satur 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) the 9□ Unknown 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes > ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate | Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of beath 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

State Registrar

Medical

31. Date filed (Month, Day, Year, OCT 2 3 2007

30. Name and address of person

29b. Signature and title of

29a. Certifier

vho completed cause of death (Item 23a) (Type, Print)

and manner stated

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number () 3) (3(

Arine Clarkenno 2/6/9

2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** William Kenneth Ewell A^{M} October 2007 5:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Arbor at Baywoods Annapolis Anne Arundel If Under † Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1)
June 21, 9. Birthplace (State or Foreign **Funeral** 1∏M 2□F Months 1923 June Virginia 228-18-9422 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County XXYes 2□No Director Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number #408 21403 United States 7101 Bay Front Drive Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married ** Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXX No Specify: ð Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Executive Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Haidee Carolyn Woodis George T. Ewell ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7101 Bay Front Drive # 408 Annapolis, Maryland 21403 Mary M. Ewell / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State Baltimore Crematory 10/23/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Services Icensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: '> 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 24 hours a certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the I 29b. Signature an D 00 29571 10/22/ Hwx Crofton mo 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 OCT 2 3 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2000

State of Maryland / Department of Health and Mental Hygien 2007 35890 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 **Physician** October 22, 2:22 P M Paul Charles Engelmann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 643 Trafalgar Drive Hagerstown 8. Date of Birth (Month, Day, Year) Aug. 16, 1929 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**⊠**M 2□ F 78 126-20-1156 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or Itema 23e or 28e-f ehow traumatic event, it e Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 643 Trafalgar Drive 21742 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★Yes 2 □ No1951—
If Yes, Give Year or Dates: 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Programmer Computer Technology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fund Mental h and Menta Otto Julius Engelmann Magdelena Heinrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an Jean Engelmann / Wife 643 Trafalgar Dr. Hagerstown, MD 21742 othar 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State October 27, cometery, cromatory or other place)
Resthaven
Memorial Gardens Department of Important: If It any Injury or o one. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Frederick, Maryland 21. Signature of Funeral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 19501 Catoctin Mtn. Hwy. Frederick, MD 21/01 23a. Part Enter the lisease, shock, or he w failure. Li Approximate Interval Between Onset and Death mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician rustate nont /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit sete hes been signed by the attending physicien and page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☑No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a Was an this certificete 2 1 No 1□ Yes or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ø No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred After t 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 041667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medocal Cames mack 31. Date filed (N legistrar's Signatura State Registrar

Division of Vital Records, P.O. Box 68760,

Registrar

State

1209

gistrar's Signature

(Que

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year MISTY 1030 AM 3 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospice 2 mico 8. Date of Birth (Month, Day, Year) 10/1/1926 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1**X** M 2□ F Hours 218-16-9067 Director 81 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exeminer must be notified at 1X Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 225 Canal park Dr., Unit 2 21804 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 Myes 2 NArmy/ If Yes, Give Air Corp 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: ģ white 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than 12 0 structural contractor George Elliott & Son 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill timent of Health and Mental H tant: If item 27 is marked other Be Edith Mae Elliott George Lloyd Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma L. Elliott/wife 225 Canal Park Dr., Unit 2, Salisbury, MD 21804 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Wicomico Memorial Park ortant: If i injury or 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or *4 □ Donation 5 □ Other (Specify) 10/27/07 Salisbury, MD permit. 2) Signature of Funeral Service Licensee ^{22, Name and Address of Facility}
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 once ¥. ario CFSP Dompoor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastata /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attanding Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760 physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 3 Probably 1 Tyes 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 22 No 22100certificate 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Tes Certification; To 1 7 atient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending death. Director: A 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) mil D26278 e of death (Item 23a) (Type, Print) IVA PU BOX 1733 egistrar's Signature 31. Date filed (Mo State Registrar

		riease	Type of Print in t					_	ie.
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		Registrar		Ce	rtificate of	Death			J07 3589:
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Examine	er	Memorial	Hospital		/-	Ston_	1	4c. County	160+
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t do man		10a. State 10b. County	10c. Cit	ty, Town or L					10d. Inside City Limits
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036 Subert Our atter deeth with the Marylar all, or Items 238 or 288-1 show Examinar must be notified at	Funeral Director	10e. Street and Number 723-Gree	nwood Ave	nue	10f. Zip Code	2/6/3	1	Og. Citizen of W	/hat Country?
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21215 ad within 72 giana na erthan 'na	n pe	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir	ed)		- 1	0
nd 2121 e filed within al Hygiene, vent, tre Me	3	17. Father's Name (First, Middle, Last)		Prod	uction	Superv	isor 1	000	Processing
Maryland nd 2 should be file the and Mental hy Z7 is marked oth	ň l	11	Elliott				ne (First, Middle, M	Maiden Sumami	3)
should be nd Menta marked imatic ev	0	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Stree	Reno at and Number or Ru		City or Town	State Zin Code)
		Mary FI	10++	723		ood Ave.		4	
ore, M ss 1 and 3 of Health litem 27		20a. Method of Disposition		Place of Disponentery, cre	osition (Name of matory or other pla	ı	Date	20d. Low tion -	City or Town, State
altimo		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	rdtou	in Comet	Lery 10/	27/07	anbr	dge, MD,
Baltimore, permit. Pages 1 at Department of Hea Important: if Item eny injury or other once.		21. Signature of Funeral Service Licen	7 7/2 7	2	2. Name and Addr	ress of Facility	Home, P.A		MD. 21613
	+	23a. Party. Enter the disease, or compshock, or heert failure. List only	olications that caused the deat	h. Do not en	ter the mode of dy	Shington	St. Came	est.	Approximate
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pe)	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):	· 01 0-	11/1	10	1) .	,
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Records, P.O. Box 68 The law requires that the death certifical site has been signed by the ettending phypage 2 should be detached for use as the state of the st	rnysician/med	1 Yes 2 No	4☐ Pregnant at time of d 9☐ Unknown	eath 5[Other (specify)			Mon	ith Day Year
Cords, P.O. wrequires that the de been signed by the should be detached	Dy P	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause g	ıven in Part I.	23e. Did tob	acco use contri	ibute to the cause of death?
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Division of Vital Records, for attending Physician: The law requires the effer death. Director: After this certificate has been signed in by the funeral director, page 2 should be considered.	2	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	ome, farm, st			28f. Location (Str	eet and Numbe	er or Rural Route Number,
Division (Is after death. Is Director: After death. ed in by the funers.		4 Homicide	building, etc. (Specifi	y) 			City or Town	, State)	
Division of Vital Re To the Hospital or Attending Physician: The within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	שנתונים	29a. Certifier 12 Certifying Phy (Crieck only one) 2 Medical Exam	rsician: To the best of my kno liter: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the t vestigation, in my	time, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and mar ite and place, a	nner as stated. nd due to the cause(s)
ro the vithin of the complex	2	29b. Signature and title of certifier	and manifer states.		29c. Licen	ise number	29	d. Date signed	(Month, Day, Year)
		> Leter 1 to	. MD		D	6335	9	10/2	3/07
		30. Name and address of person who o	ompleted cause of death (Item	23a) (Type,	Print)		17.	1 -	EASTONI.
l)		MAHBUBA	ALCHTER	2,6	07 DU	TCHMA	N'AL	ANE,L	ID+21601
State Registra		31. Date filed (Month, Day, Year) OCT 2 5 2	32. Prigistrar's Signa	ture	handle.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O FRY o 7 **Physician** BEATRICE 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harwood

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. Feb. 8, Anne Arundel Hospice of the Chesapeake - Mandrin 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Arkansas 1 M 2 F 83 Director 429-18-4032 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes XX No Directo Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a the Medical Examiner must b United States 21403 2013 Harbour Gates Drive by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XX Yo Specify White ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pount. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic many injury or other traumatic many injury or other traumatic Elementary/Secondary (0-12) College (1-4or 5+) Owner/ Manager Lumber Yards 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Beatrice Baggett Hugh R. Rogers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Martha S. Adams / Niece 464 Valverda Drive The Villages, Florida 32162 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Restland Cemetery Dallas, Texas 4 □ Donation 5 □ Other (Specify) nd Cemetery 10/27/2007 Dallas, Texas

22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signatur Truneral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. set and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknow s been signed by the Part II. Other significant conditions contribut 23e. Did tobacco use contribute to the cause of death? ting to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has bage 2 s certificate or Attending Physiclan: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence P 1 ☐ Yes 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Leath 1 Natural 2 Accident After this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route City or Town, State) filled in by 4 Homicide Hospital Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

the

Medical

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only

ignature and title of certific

Dr. Michael LaPenta

445 Defense Highway 32 Registrar's Signature

30. Name and address of person who empleted cause of death (Item 23a) (Type, Print)

OCT 2 3 2007

29d. Date signed (Month, Day, Year)

Annapolis, Maryland 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 8:30 PM 2001 Craig OCTOBUL Κ. Grant 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S DOCTOR'S HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/30/1968 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 1XM 2□ F SOUTH CAROLINA 38 249-57-6805 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No PRINCE GEORGE'S LANHAM 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 USA 6323 KINSEY TERRACE 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: ARMY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) MORTGAGE LOAN OFFICER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FRANKLIN R. GRANT LOUVENIA JACKSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6323 KINSEY TERRACE LANHAM, MD 20706 19a. Informant's Name/Relationship (Type. Print) ERICA M. GRANT/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1XX urial 2 □ Cremation 3 □ Removal from State GLENWOOD CEMETERY 10/26/07 FLORENCE, SC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MD 20785 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOGENIC SHOCK disease or condition resulting in death) Due to (or as a consequence of): SEPTICEMIA Due to for as a conse juence of STAPHYLOCOCCAL PNEUMONIA Due to (or as a consequence of):

Physician /Medical Examiner

attending physician

signed by t Id be detach

page ;

certificate

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Funeral Director: stely filled in by the

To the Hospital or Attending Physician:

24

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Completed

Be

To

Certification:

Medical

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show aminer must be notified at

Director

Funeral

Completed by

MD

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iten

artment of Health ortant: If item 27 i injury or other

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The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Maryland 21215-0036

Baltimore,

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical

DISSEMINATED INTRAVASCULAR COAGULATION

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

Month

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown

23d. Date of delivery

HYPERTENSION 25. Was case referred to medical

examiner'

RENAL FAILURE

24a. Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one)

LANHAM, MD

 Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 2□No

Year

1XYes 2□ No 27. Manner of Death 1 Natural 2 Accident 5 ☐ Pending investigation 6 Could not be determined 3 ☐ Suicide 4 Homicide

1 Inpatient 2 ER/Outpatient 3 DQA Date of Injury 28b. Time of (Month, Day Year) Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number DG1550 29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6000 31. Date filed (Month, Day, Year)

State. 2 5 2007 Registrer

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Gary Lee Grigsby October 23, 2007 12:15 P.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11405 Maryvale Road Upper Marlboro Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day), Hours | Min. | 3. Date of Birth (Month, Day), June 23, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) (Country) (1933 Washington, D.C. Months 1 XM 2 □ F 579-44-6517 74 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges Upper Marlboro 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11405 Maryvale Road 20772 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11 Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Offset Printing Printer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Thomas Grigsby, Sr. Grace Madeline Erhardt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11405 Maryvale Road, Upper Marlboro, MD 20772 Patricia Anne Grigsby/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ceo Wash. University October 23
Medical Center 2007 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 Donation 5 ☐ Other (Specify) 2) Since tur of Funeral is rvice Lipensee 22. Name and Address of Facility Columbia Mortuary Services, P.A. 9013 Annapolis Road, Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cryse on each line. Approximate Interval Between Chaet and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 TYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

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Director

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Director

Funeral

Completed by

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Examiner

Physician/Medical

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Certification: To

Medical

death with the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be flied within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Medical

Baltimore, Maryland 21215-0036

and burial-tra attending physician as the use for the detached signed by the sign of the sign been has page 2 certificate I director. this funeral After after death Director:

Physician: The law requires that the death certificate be executed

or Attending

Division or Vital Records, P.O. Box 68760,

27. Manner of Death

1X Natural

2 Accident

3 ☐ Suicide

4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 🗌 Yes 2 ∏ No

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

tx Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

29c. License number

LINE LEWER

29d. Date signed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print) 30: Name and

Day, 5 2007

32. Registrar's Signatu

State Registrar

filled in by

24 hours a Hospital

within 2

07-08389	
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State of Maryland /	Department of He	ealth and Mental	l Hygien

2	0	0	7	3	5	8	9	*
		_		~	\sim	\sim	-	

mes Daniel G	1	- For State Cert	ificate of Death	Reg. N	2007 358
Physicia	n/	egistrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
edical Exami		JAMES DANIEL GRADY, SR.	4b. City, Town, or Location of	Month Day October 28, 2	4c. County of Death
	н	4a. Facility Name (if not institution, give street and number) Bowie Health Center	Bowie	Death	Prince George's
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday) If Under 1 Year If Unde	r 24Hrs. 8. Date of Birth (M	M/DD/YYYY) 9. Birthplace (State or
Director		212-72-3303 1½ M 2 F 49	Yrs. Months Days Hours	Min. 07-01-19	Foreign Country Wash., DC
any	ŀ	Usual Residence of Decedent 10a. State	Town or Location		10d. Inside City Limits
Aaryland 28a-f show 1 at once.	٦	Maryland Prince George's	Beltsville		1 Yes 2 No
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teelth and Mental Hygiest teelth, and Mental Hygiest tee 27 is marked ofter than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number 10405C 46th Avenue #104	10f. Zip Code 20705		Ditizen of What Country?
with ms 23; be not	eral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican	gin? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.
or ite	Funeral	Never Married 2 No 1 Yes 2 No	1 Yes 2 * No specify:		Specify: White
rs after rral", niner	<u>S</u>	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give		5. Kind of Business/Industry
2 hour "natu	ğ	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT	use retired)	
5-0036 Iled within 72 Hygiene. d other than "	Completed	12th	Stock Clerk		Private Industry
5-0 iled wi Hygie I other		17. Father's Name (First, Middle, Last)		's Name (First, Middle, Maid	
2121 2121 Juld be fi Mental I marked	o Be	David L. Grady 19a, Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Nur	ggy V. Danuel	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within perment. Pages I and 2 should be filed within Important: If item 27 is marked other thingury or other traumatic event, the Med	ř	Gina A. Grady/wife	10405C 46th Ave.		7
e, N and 2 Health item 2	-	20a. Method of Disposition 20b. F	Place of Disposition (Name of cemetery, rematory or other place)		Oc. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		Ceda	ar Hill Cemetery	11-02-2007	Suitland, Maryland
altin mit. P partme porta ury or	i	21. Signature of Funeral Service Licensee	22. Name and Address of Facilit		
ii ii Pe m	- 3	Mary Hedgman M01374	Cedar Hill FH	4111 PA Ave.	Suitland, MD 20746 shock, or heart Approximate Interval
Physician /Medical		23a, Part I. Eyfter the disease, or complications that caused the death. failure. List only one cause on each line.		cardiac of respiratory arrest,	Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Due to (or as a consequence of	cardiovascular disease		Deasi
		Sequentially list conditions,	p.		
	ner	if any, leading to immediate cause. Enter Underlying Cause	f):		
	caminer	(Disease or injury that initiated events resulting in death) Last	():		
60, ate be executed hysician and e burial - transit	al Ex	d			
of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed Mer this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial - transimeral director, page 2 should be detached for use as the burial - transi	Physician/Medical	X UNPENDED AMENDED #23a.PII.27.per	ME. <u>9873</u> . 11/9/07 TT		
6876(certificate nding physes as the b	n/Me	23b. Was decedent pregnant in the	laticy	ic pregnancy	23d. Date of delivery Month Day Year
Box 6876 he death certificate retificate relations to the attending phy hed for use as the least researcheres.	icia	past 12 months? 4 Pregnant at time of de			
Bo le deat the at the at	hys	1 Yes 2 No 9 Unknown g Unknown	hi the state in D	23e Did toba	cco use contribute to the cause of death?
ires that the signed by a be detached	by P	Part II. Other significant conditions contributing to death but not re Cirrhosis of liver, hydronephrosis			2 No 3 Probably 4 V Unknown
rds, Frequires been sign			s due to difficily trace		24b. Were autopsy findings available
COFC law rehas be 2 shor	ompleted	infection		autopsy performe	
tal Rec	Con		26 Place of Death	1 Yes 2	No 1 Yes 2 No
Vital I ysician: his certifi director,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other		sidence 6 Other:
of Vit ling Physic After this funeral dire	-: To	1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Wor	rk? 28d. Describe how	v injury occurred
	tion	1 X Natural 5 Pending	1 Yes 2	No	
Division tal or Attendii ss after death.	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At h	ome, farm, street, factory, office building, e	etc. 28f. Location (Street or Town, State	eet and Number or Rural Route Number, City
pital ours a filled	Certification:	4 Homicide determined (Specify)			
Division To the Hospital or Attendia within 24 hours after death. To the Fineral Director: 1 completely filled in by the fi		29a. Certifier (Check only one) Quantifier 1 Certifying Physician: To the best of my knowled (check only one) Medical Examiner: On the basis of examination a	ge, death occurred at the time, date and p and/or investigation, in my opinion, death o	lace, and due to the cause(s occurred at the time, date an	s) and manner as stated. d place, and due to the cause(s)
To t withi To t	Medical	and manner stated. 29b. Signature and title of certifier	29c. License numbe		29d. Date signed (Month, Day, Year)
	_	hig hi. mid	O.C.M.E.		October 29, 2007
R		30. Name and address of person who completed cause of death (Item Ling Li, MD Assistant Medical Examiner 111	Penn Street, Baltimore, MD 21	201	
	tate	31. Date filed (Month, Day Year) 32. Registrar's Sign of	ure		
Regis	urar	OCME	ODICINAL		

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2007Certificate of Death 2. Date of Death 3. Time of Death Month Day Year October 20, 2007 **Physician** Frances Mae Gottschalk 2:45 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Chevy Chase Manor Care-Chevy Chase ocial Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yes Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 499-10-0330 91 Director Jan. Missouri Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 No Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 3 10545 Wheatley Street 20895 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: White Completed by If Yes, Give Year or Dates: 3 Vidowed 4 □ Divorced other than "natu vent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If Item 27 is marked other any Injury or other traumatic event; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred A. Jenkins Mary V. Bennett ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Arthur Gottschalk/Son 7710 Maple Avenue, #1010, Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Oct. 24, 2007 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery O 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia /Medical Due to (or as a consequence of): **Examiner** Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Dementia More than 10 burial-trar Due to (or as a consequence of) years Box 68760, Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No or Attending Physician: director, 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital of 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number

Division or Vital Records, To the Hospital within 24 hours a To the Funeral L

> 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and fitle o

30. Name and address of person who

Susan J. Miller, MD

certifier

32. gistrar's Signature

completed cause of death (Item 23a) (Type, Print)

D35579

6844 Tulip Hill Terrace, Bethesda, MD 20816

29d. Date signed (Month, Day, Year)

MD

Year

Chestertown, MD 21620

Registrar DHMH 17 Rev 1/2001

State

12

6602 Church Hill Rd.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Frederick 31. Date filed (Month, Day, Year)

OCT 2 2 2007

Delboy, MD

egistrar's Signature

			For State	State o	f Maryland	-	artment rtificate			-	_	/ 11	07	359	a n 1
			Registrar 1. Decedent's Name (First, Middle, L	ast)			imeate	0, 000		2. Date of De	Reg. No			3. Time of De	
	Physici		Lillian May Hil	nart						Month Octobe	Da r 20	•	ear	6:14	рΜ
	/Medio		4a. Facility Name (If not institution, g		mber)		4b. City, To	wn, or Loca	ation of Death			. County of		0.14	<u>+</u>
		s@	958 Firetower R	oad			Co	lora				Ceci1			
	Funeral		7	Sex 1 □ M 2 X F	7. Age (In yrs. I		If Under 1 Months [Inder 24 Hrs. ours Min.	8. Date of Bir (Month, Da	th y, Year)	9	. Birthpla	ace (State or Fi	oreign
-	Director		188-42-1660 Usual Residence of Decedent	ILIWI ZUALF		106 ^{Yrs.}				June 1			PA		
	and ow		10a. State 10b. County		10c. City	, Town or Lo	cation			-			10	d. Inside City L	Limits
	Mary -f sho iled a	호	Maryland	Cecil		Color								1 □ Yes 2	∑ No
	r 28a	Director	10e. Street and Number	Cecii		_00101	10f. Zip C	ode			10g. Cit	izen of Wh	at Count	ry?	
	th wit		958 Firetower R	oad				21917			US	A			
	r dea	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.S	S. 13.	Was Deceder	nt of Hispani	ic Origin? (S	pecify Yes or No o Rican, etc.)	-	14. Race -	America White, e		
36	and 2 should be filed within 72 hours after death with the Maryland nath and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show the traumatic event, the Mcdical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv	2.∭ No ve		1 □ Yes 2 %		ecify:			Specify:			
21215-0036	hour tural	ed b	15. Decedent's	Year or D	ates:	16a Dece	dent's Usual (Occupation			16h K	ind of Busin	Wh i		
15	n "ne n "ne Medic	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1	I dor E ()	(Give	kind of work DO NOT use	done durina	most of wor	king	100.11	nia or Badii	1000/1110	acti y	
212	d with giene ir tha the	E	8	College	1-401 5+)	Cler	ical				Pha	rmace	utio	a1	
	al Hy l othe	Be C	17. Father's Name (First, Middle, Las	st)				18. N	Mother's Nan	ne (First, Middle,	Maiden	Surname)			
Maryland	ages 1 and 2 should b nt of Health and Ment: : If item 27 is marked : or other traumatic e	인	Edward F. Dold			,				Strodic				_	
/ar	2 sh and is m		19a. Informant's Name/Relationship							ıral Route Numb					
	1 and Health em 27 ther t	13	Ruth Alexander/1 20a. Method of Disposition	Daughter					11 Cov	e, Beth		Beach ocation - Ci			
Baltimore,	ages nt of t: If its		1 XBurial 2 X Cremation 3		Siale		sition (Name natory or oth								
Ħ	permit. Pages 1 Department of He Important: If iter any injury or oth		4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic		GIE	22	2. Name and	Address of F	Facility	10-27-2			nall	, PA	-
B	Dep lmp any		Kichard &	P	rodie.	1	R. T. 1	Foard	Funer	al Home, et. Risi			vm 2	1911	
Ĭ.	48.9		23a. Par . Enter the dispase, or co shrick, or heart failure. List on	mplications that o	aused e death							7.056 (56 5		Approximate Interval Between	en
	Physician		Immediate Cause (Final disease or condition	47	. 7	1 6	m Ret							Onset and Dea	ath Q
9	/Medical Examiner		resulting in death)	- Car	or as a consequ		, , , ,								
E.	Lxammer	_	Sequentially list conditions,	b. Re	ned Fo	all and							1	Zyens	5_
RT	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Die to t	(or as a consequ	ionico ory.								•	
· .	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c Due to	or as a consequ	ence of):			_				+		
8760	cate be executed oblysician and the burial-transit	dical		d											
Φ.	ng ph as th	Med	IF FEMALE:			-									
Вох	leath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come pf pregnar	death 3[Ectopic preg	ınancy			90	23d. Date o		,	
	ne dea the at hed fo	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregr 9□Unkn	ant at time of de own	eath 5	Other (spec	ify)				MOLIT	1 1	Day Yea	Л
P.0	that the de led by the a detached t		Part II. Other significant conditions	contributing to de	eath but not resu	Itina in the u	nderlving cau	se given in F	Part I.	23e. Did to	obacco i	use contrib	ute to the	e cause of deat	th?
Vital Records,	uires tha signed d be del	d by	Osteanmas	3 , C	rantores	on leas	0 0	Plus	DROGE	5 1 _□	Yes 2	₽ √√0 3	☐ Proba	ıbiy 4 ∐Unk	known
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Re	The lay e has age 2	Completed					·			autop	osy rmed?_	prid dea	or to com ath?	pletion of caus	se of
ta	sician: The certificate ha rector, page	Be C	25. Was case referred to medical					26. 1	Place of Dea	1 Yes ith (Check only o	2 1 No	1]Yes :	2 □ No	
	Physici this cer al direc	ToB	examiner? 1	Hospital:	npatient 2 🗆 E	ER/Outpatier	it 3□ DOA	Othor		ome 5 Resid		6 □Other	(Specify)	
n or	ding Pr .r After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	280	. Injury at Work?		28d. Describe l				<u>-</u>	
Sio	Attendi death. ctor: A y the fu	catic	2 Accident investigation				М	1 ☐ Yes	2 □ No						
Division	or At after d Direct in by	ertification:	4 Homicide determine	28e. Place buildi	of injury - At horning, etc. (Specify	me, tarm, str	eet, factory, c	office		28f. Location (3 City or Tox	Street ar vn, State	nd Number e)	or Rural	Route Number	τ,
	spital ours a neral filled	O	29a. Certifier 1 Certifying F	Physician: To the	best of my know	vledge, deat	occurred at	the time. da	ate and place	and due to the	causels) and mann	er as sta	ated	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 brous after death. The Line Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	(Check only 2 Medical Example)	aminer: On the b	asis of examinat ner stated.	ion and/or in	vestigation, ir	n my opinion	n, death occu	irred at the time,	date an	d place, an	d due to	the cause(s)	
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Ĭ	29b. Signature and title of certifier	/ . 1	1 1			icense num			29d. Da	te signed (Month, E	Day, Year)	
			Juseph K	., Wen	the d	RMO		POOU	14373		10-	22	20	07	
			30. Name and address of person who	completed caus	e of death (Item	23a) (Type,	Print)			7			_		
	6		31. Date filed (Month, Day, Year)	16114ER	offictraric Cianat		COLOI	VIAL	WAY	Risino	· SUA	MU	2	1911	
	Sta Registr		OCT 2 5	2007	e g istrar's Signat	S. A	parte								

1 For State		State of	of Marylan	•							0 = 0 0 0
Regist	rar t's Name (First, Middle	/ast)	<u>.</u>	Cei	tificate	of Death		Re 2. Date of Death		07	35902
Physician Dor	othy C. He	nnessey					C	Month	^{Day} 2	Year 007	5:17 A M
, Examino	Name (If not institution, Arundel Med					vn, or Location Annapol			4c. County Ann		undel
Director 578–1	6-2824	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 86		If Under 1 \ Months D	ear If Under ays Hours	Min.	B. Date of Birth (Month, Day, Peb. 2,	Year) 1921	Cour	lace (State or Foreign try) ington, DC
0	and Anne	Arundel	10c. Cit	y, Town or Lo		napolis				1	0d. Inside City Limits 1 ☐ Yes 2221No
Iffer death with the Mar fifter death with the Mar fifter death with the Mar fifter must be notified. Tuner must be notified at 10° Street 50° Street 10°	and Number Compass Di	rive			10f. Zip Co	de 214	01	10	g. Citizen of V	What Cour	•
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Tohn Tohn	ant's Name/Relationsh R. Henness		'son	19b. Mailin 2456	g Address (S Shadyt	reet and Numb	er or Rural rcle	Route Number, Croftor	City or Town,	State, Zip land	Code) 21114
altimore, mit. Pages 1 a portant: If item y Injury or othe 21. Signature 21. Signature 21. Signature 22. Signature 23. Signature 24. Signature 25. Signature 26. Signature 26. Signature 27. Signature 28. Signature 28. Signature 29. Signature 20. Method	d of Disposition rial 2 □Cremation nation 5 □ Other (<i>Sp</i>			Place of Disponentery, creme e of He			Dai y 10/2	te 2 26/2007	Silve	•	own, State
Baltimore Permit Pages Department of Financial File Doors Department of Pages Doors	Funer Service L	icensee X	ller					M. Tay			L Home , MD 21401
Physician Immediate disease or	Enter the disease, or or or or or or or heart failure. List of Cause (Final condition	only one cause on	caused the deat each line.		er the mode o	f dying, such as	s cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
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ψ if any, lead	y list conditions, ng to immediate er Underlying accounting devents death) Last	с	(or as a conseq	,							
care be executed or the burial-transit the burial-transit the burial-transit dical Examir dical Examir		d.	(or as a conseq	uence oi).							
BOX 6 death certification of the certification of	ecedent pregnant past 12 months? es 2 💆 No nknown	1 ☐Live	utcome pf pregna birth 2 Feta nant at time of d	ıl death 3□	Ectopic pregi Other (speci				23d. Dat	te of delive	ery Day Year
The law requires that the de tate has been signed by the a page 2 should be detached to mpleted by Physic	er significant conditio	ns contributing to c	death but not res	ulting in the ur	nderlying caus	e given in Part	1.	23e. Did tob			ne cause of death?
								24a. Was an autopsy perform	ned?	Were auto prior to co death? I Yes	psy findings available mpletion of cause of 2 No
Vital Resident: The side of t		Hospital:	Hanationt O	FB/Outration	4 00 004	Other		Check only one			
Division or Vita or Attending Physician: iffer death. Director: After this certific in by the funeral director, in by the funeral director, and was as examine. 72. Wasus A Ho A Ho A Ho A Ho A Ho A Ho A Ho A Ho	of Death ural 5 ☐ Pending	28a. Date (Mor		ER/Outpatien 28b. Time of Injury		Injury at Work? 1 ☐ Yes 2 ☐	28	e 5 Resider			у)
Division C Waunus Staffer death. Tail Director: After led in by the funert After led in by the funert After led in Py Hop Certification: Certification:	cide 6 ☐ Could n	ot be 28e, Place	e of injury - At ho ding, etc. <i>(Specif</i>	ome, farm, stre	eet, factory, o	fice	28	f. Location (Str. City or Town,		er or Rura	d Route Number,
Divisit To the Hospital or Attent within 24 hours after death within 24 hours after death to the Funeral Director: Completely filled in by the Medical Certificat Medical Certificat Medical Certificat Signal Certificat The Population of the Control of the	only 2 Medical E	Physician: To the Examiner: On the b	e best of my kno basis of examina nner stated.	owledge, death ation and/or inv	occurred at vestigation, in	he time, date a my opinion, de	ind place, areath occurred	nd due to the ca	use(s) and ma ate and place,	anner as s and due to	tated. the cause(s)
29b. Signat	ure and title of ertifier	Sel	250	ND	29c. Li	D5851	0	29	Octob		Day, Year) 2, 2007
TIVUY	nd address of person v		se of death (Item 2 Medica			nnarol i	is. Ma	rvland	21401		
	oct (Month, Day, Year)	20.1	Redistrar's Signa	tura			- Ly Link		21301		

			1 = For State Registrar	State of Mar		artment of F rtificate of			/	35903
			Decedent's Name (First, Middle, La	st)		runouto or		2. Date of Death		3. Time of Death
	Physic /Medi		Milton	Patrick Ha	rlow, Jr	•		October	Day Year 23, 2007	9:10A M
	Exami		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Dear	th	4c. County of Deat	h
			24915 Ridge Roa 5. Social Security Number 6. S		In use last history	Damas If Under 1 Year		0.0	Montgom	
	Funeral Director		579-38-0308	WT	n yrs. last birthday) 75 Yrs.	Months Days	Hours Min	(Month Day	Year) 9. Birtl Co 1932 Was1	hplace (State or Foreign untry) hington, DC
	fand fand		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary	to	Maryland Montgome	rsy	Damascus					1 ☐ Yes 2 X No
	th the	Director	10e. Street and Number	Ly	Damascus	10f. Zip Code		10	g. Citizen of What Co	untry?
	23a (23a unit	alD	24915 Ridge Road			20872		us	SA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, it a Medical Exartment terrotified at ODGE.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Even Armed Forces? 1 X Yes 2 □ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	2 hours	ed	15. Decedent's E	Year or Dates: 1 C		dent's Usual Occup	ation	11	Whi Sb. Kind of Business/	
215	hin 72 In "na Media	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wa	rking	DD. Raid of Edulinosay	industry
2	or tha	E OC	12	College (1-401 5+)	Taxi	Cab Drive	er	I	ransportai	tion
nd	d oth	Be	17. Father's Name (First, Middle, Last,				18. Mother's Na	me (First, Middle, Ma	aiden Sumame)	
Z	a Men nerke	ို	Milton Patrick Ha					Isabelle T		
Za	d 2 st th and th and traun		19a. Informant's Name/Relationship (_					City or Town, State, Z	
ē,	Heal Heal tem 2		Theresa Weaver, d. 20a. Method of Disposition		20b. Place of Dispo	sition (Name of		7e, Mt. Ai	ry Maryla	and 21771 Town, State
E	Pages ent of nt: if i		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		•	natory or other place	1			
Baltimore, Maryland	partm ports y inju		21. Signature of Funeral Service Licer		22	2. Name and Addre	ss of Facility Mc	1/2//2007	Silver Spi	ring, Maryla Funeral Home
<u> </u>	88.58		Han M.	Deran	2	6401 Ridg	e Road.	Damascus.	Maryland	20872
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arres	it,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Metert	stiz 1	lon (mall	(ell 1	Lung Con	.00	Onset and Death 4 Months
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):			7		77713
		ē	Sequentially list conditions if any, leading to immediate	Due to (or as a c	onsequence of):					
	ored ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	, , , , , , , , , , , , , , , , , , , ,						
o,	exec en an rial-tr		resulting in death) Last	Due to (or as a c	onsequence of):					
58760,	ficate be executed physicien and is the burial-transit	dlcal		. d.						
_	artifica ing pt e as t		IF FEMALE:							
Вох	death certifi e attending d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 Live birth 2 [4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delin	very Day Year
0	at the de by the a tached	hys	9 Unknown	9□ Unknown						
	faw requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.		cco use contribute to	the cause of death?
ord	w require been sig should t	ted						1 XYes	2 □No 3 □ Pro	bably 4 Unknown
Records,	a taw i	Completed						24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of
	: The lav	ပိ						performe	death? ZNo 1 ☐ Yes	
Division of Vital	or Attending Physicien: Ifter death. Director: After this certification by the funeral director, p.	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only one)		
ö	Phys rrthis sral di	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatien 28b. Time of	t 3 DOA	4 ☐ Nursing H	28d. Describe how	ce 6 Other (Spec	ify)
<u>o</u>	nding I ath. r: After e funer	at lor	Natural 5 Pending investigation	(Month, Day Ye	ear) Injury	Work	r? Yes 2 □ No	200. 5000120 11011	injury cocurred	
<u> </u>	ofter death. Director: A Jin by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	At home, farm, stre	eet, factory, office			et and Number or Rui	ral Route Number,
<u> </u>	rs efter rs efter rei Die	Cer		building, etc. (c	эрвспу)			City or Town,	State)	
	To the Hospital of within 24 hours of To the Funeral D completely filled in	edlcal	29a. Certifier (Check only one) 1 ☐ Certifying Ph- 2 ☐ Medical Exam	ysician: To the best of m iner: On the basis of ex- and manner stated	amination and/or inv	occurred at the timestigation, in my of	e, date and place pinion, death occu	o, and due to the cau irred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier			29c. License	number	290	. Date signed (Month	, Day, Year)
	· NX		Paul Barren	MO		006	2250	0	ctober Z	4,2007
4	Lla		30. Name and address of person who		(Item 23a) (Type,	Print)		N	- Ma-	
	Sta	e	31. Date filed (Month, Day, Year)	32 degistrar's	Signature	rive 5	27 0	ney, MO	20855	_
	Registr		OCT 2 6 20	07 Bleeve	Signature Signature	W				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 8:00^a M Edward Thomas Honaker 2007 October 21, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10700 Cavalier Drive Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Country) Months Days Hours XXM 2 F 235-80-3043 57 Jan. 17, 1950 West Virginia Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2x No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10700 Cavalier Drive 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Specify: White 1 Yes 35 If Yes, Give Year or Dates: 1 ☐ Never Married XX Married 3 No

Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)

3 Widowed 4 Divorced

Funeral

Director

r 28a-f show notified at

ms 23a or 7

ural", or items 2 Il Examiner mu

'natural' the Medical

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once.

Physician

/Medical Examiner

burial-tra

attending physician for use as the burial

the

Completed by

Be

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Examiner

Physician/Medical

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Completed

Be

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Certification:

Medical

funeral

death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Glazier Construction 18. Mother's Name (First, Middle, Maiden Surname)

Specify.

(Give kind of work done during most of working life. DO NOT use retired)

Edward Thomas Honaker

Virginia Lee Reckard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type. Print) Camille S. Honaker/Wife

10700 Cavalier Drive, Silver Spring, MD 20901

20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 ☐ Removal from State

4 Donation 5 Dother (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Date Oct. 2007 Metropolitan Crematory

1 ☐ Yes 2 No

16a. Decedent's Usual Occupation

20c. Location - City or Town, State Alexandria, Virginia

16b. Kind of Business/Industry

21. Signature of Funeral Service Licensee > Hnewarieldames

15. Decedent's Education (Specify only highest grade completed)

Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last

Immediate Cause (Final

a. :	COTOH CSHEET
	Due to (or as a consequence of):
b.:	
	Due to (or as a consequence of):

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

College (1-4or 5+)

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Tyes 2 TxNo 3 TProbably 4 TUnknown 24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred

1□ Yes

1 ☐ Yes 2 □ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

D62234

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9707 Medical Center Drive, Rockville, MD 20850 Manish Agrawal, MD

State Registrar

31. Date filed (Month Day Year) 2007



DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed been signed by should be detact has certificate Physician: this Hospital or Attending After after death filled in by the within 24 hours a

1 ☐ Yes 2 No 27. Manner of Death 1 Natural

2 Accident 3 Suicide

29a. Certifier

(Check only one)

4 Homicide

29b. Signature and title of certifier

determined

6 Could not be

5 Pending investigation

28a. Date of Injury

(Month, Day Year)

28b. Time of

Location (Street and Number or Rural Route Number, City or Town, State)

perforr

29d. Date signed (Month, Day, Year)

October 22, 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 9:30 P^M OCTOBER 23 JOE LOUIS **JAMES** 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 6511 LANDOVER ROAD # 201 CHEVERLY PRINCE GEORGE'S Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Days Hours 1 M 2 □ F 72 23 1935 Virginia Oct. 231-42-3442 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural;" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1√ Yes 2 No Director PRINCE GEORGE'S CHEVERLY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 6511 LANDOVER ROAD # 101 20785 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ò 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7TH College (1-4or 5+) PRIVATE TRUCK DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LOLA COLES JOHN JAMES ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 DWYER PLACE LARGO, MARYLAND BRENDA JAMES BALL/DAUGHTER 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Bapt Church 10/29/2007 GRENTA, VIRGINIA Mt. Olive 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ADVANCED HEART FAILURE /Medical Due to (or as a consequence of) **Examiner** CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit HYPERTENSION that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a <u>Б</u> 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by CHRONIC USE OF ALCOHOL 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No 24a. Was an autopsy performed? Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending 1 X Natural 1 Yes 2 No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cer. D12863 2007 October 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6005 Landover Road Cheverly, Maryland 20785 Hassan A. Molavi M.D. 32. Registrar's Signature 31. Date filed (Month, Day State OCT 2 5 2007 Registrar

			1 - State of Marylar Registrar	-	artment of H				07 35907
7	Physici	an	Decedent's Name (First, Middle, Last) Beth L. Jones				2. Date of Dea Month October	ath	3. Time of Death 2007 4:00 p M
	/Medid Examin		4a. Facility Name (If not institution, give street and number) 558 Stoney Hill Court		4b. City, Town, or	Location of Death		4c. County	
	Funeral Director	2	5. Social Security Number 5.54-41-9889 6. Sex 1 □ M 2 M F 47	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Apr 07		9. Birthplace (State or Foreign Country) California
	D			ty, Town or Lo					10d. Inside City Limits
	h the Mar or 28a-f st e notified	Funeral Director	10e. Street and Number	Odentor	10f. Zip Code			10g. Citizen of V	1 ☐ Yes 2 💢 No What Country?
	death wit	neral D	558 Stoney Hill Court 11. Marital Status 12. Was Decedent Ever in U Armed Forces?	.S. 13.	21113 Was Decedent of Hill Yes, specify Cuba		pecify Yes or No-	USA 14. Race	e - American Indian,
900	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	d by Fu	1 Never Married 2 Married 1 Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:	o Rican, etc.)	Specify	k, White, etc. White
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done o DO NOT use retired HOMEMAKE!	during most of wor)	king	16b. Kind of Bu	usiness/Industry
and 2	d be filed v ental Hygie ced other I c event, th	Be	17. Father's Name (First, Middle, Last) Theo Rayner		TIONICALENCE	18. Mother's Nan	ne (First, Middle, Osborn		
Mary	nd 2 shoul alth and M 27 Is marl r traumati	To.	19a. Informant's Name/Relationship (Type. Print) Amy L. Jones/ Daughter		ng Address (Street a				
more,	Pages 1 a lent of Hea nt: If item ry or othe		1 D Burial 2 Cremation 3 D Removal from State	cemetery, cren	sition (Name of matory or other plac 1 Cemete		•	20c. Location -	City or Town, State
Balti	permit. Departm Importa any inju		21. Signature of prioral Service Licensee	22 E 4	Name and Address Barranco & 195 Gov. I	s of Facility	P.A. Sev	erna Pai erna Pai	rk Funeral Home rk, MD 21146
ā	Physician		23a. Part1. Enter the disease, or complications that caused the dear shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	h. Do not ente	er the mode of dyin	g, such as cardia	or respiratory an	rest,	Approximate Interval Between Onset and Death
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ļu .	ecuted ind transit	Examiner	Cause. Chisease or injury that initiated events resulting in death) Last Due to (or as a consect cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consect cause of the consect cause).	uence of):					0
8760,	cate be executed oblysician and the burial-transit	dical Ex	Due to (or as a consected.	uence of):	,				
O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown 23c. If yes, outcome pf pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 0 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)				te of delivery nnth Day Year
Q	juires that the de n signed by the a ld be detached t	Ď	Part II. Other significant conditions contributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.			ribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
Records,	The law requir ate has been si page 2 should l	Completed	Vasculity mellin	<u>~</u>		- 114	24a. Was a autop perfor 1 Yes	rmed?	Were autopsy findings available orior to completion of cause of death? I □Yes 2□No
Vital	Attending Physician: The r death. ector: After this certificate ha et the funeral director, page	Be	25. Was case referred to medical examiner?		l out		th (Check only or		
0	Phys r this ral dir	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ 27. Manger of Death 28a. Date of Injury	ER/Outpatien		4 LI Nursing H		lence 6 Goth	
0	nding th. :; Afte e fune	tion	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	Work	?ົ ∕es 2∐No	200. 50001150 11	ow injury occurr	60
Division or	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At h building, etc. (Special Country of the cou	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	itreet and Numb n, State)	er or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my known one) Certifying Physician: To the best of my known one of the best of the best of my known one of the best o	wledge, death	vestigation, in my op	oinion, death occu	, and due to the d rred at the time, d	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
	or To	Σ	29b. Signature and title of certifler		D4	number 6/8/0/	2	29d. Date signed	d (Month, Day, Year) tober 22 2007
	Boh)	30. Name and address of person who completed cause of death (Iter Donna Chambers MD 133	123a) (Type, I	ense Hu	y Suit	te 1121	Annaho	tober 22 2007 lis MD 2140
E	Sta Registr	_	31. Date filed (Month, Day, Year) 32 Registrar's Signa 0CT 2 4 2007	K /					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year rene 59 GINICA 200 /Medical 2 ก 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospitla Columbia HOWARD | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | Feb., 21, 1932 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland 75 219-32-2016 Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Director MD Howard Columbia 1 T¥Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5495 Cedar Lane, #505 21044 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married 1 Yes M No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black þ 3 ☐ Widowed ► Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other the any injuc, or other traumatic event, the ones. 8th Domestic Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton Pierson Ethel Sturgis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5732 Yellow Rose Ct, Columbia,MD 21045 Peggy Lee Jones (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Bucial 2 ☐ Cremation 3 Removal from State Arbutus Mem Park 10/27/07 Catonsville, MD 4 Dopation 5 ☐ Other ture of Funeral S 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 e, or complications that caused the death. List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ptic 0 /Medical Due to (or as a consequence of): Examiner NEUMONI Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-t Due to (or as a consequence of): physician Physician/Medical the as attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an , page 2 certificate has autopsy perform 212 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manper of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending

within 24 hours af

To the Funeral D

completely filled i Medical the (2

State

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifie

29c. License number 00

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

946

FWBERRY DR. COLUMBIA

5 2007

			1 - State of Maryland / Departi	ment of Health and Micate of Death	lental Hygier	ne No O O O T	05000
n.	Physici		1. Decedent's Name (First, Middle, Last) Martha Marie Jones		2. Date of Death Month Oct. 20	B ^{ay} 20ŏ°7	3. Time of Death 2:43 P M
	/Medic			o. City, Town, or Location of Death		4c. County of Deat	
	*	•	Holy Cross Hospital	Silver Sprin	ıg	Montgom	nery
	Funeral Director		579-58-8729 1 M 25xF 66 Yrs. M	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Yes 11-22-4	0 Pietl	hplace (State or Foreign untry) I • C •
	and ww		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
	Maryl -f sho ied al	ţō	D.C. N/A Washingt				M □Yes 2□No
	h the or 28a o notifi	irec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	untry?
	23a c	ral	1601 Argonne Place, N.W. #401	20009		U.S.A.	
	er dea items	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was If Ye	Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
5	rs aft	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1	Yes 2XNo Specify:		Specify: B1	ack
5	2 hou atura		15. Decedent's Education 16a. Decedent	's Usual Occupation	16b	. Kind of Business/	Industry
7	thin 7 ee. an "n Medi	Completed		d of work done during most of work NOT use retired)		a	
7	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at			ol Teacher			c Schools
2	d 2 should be filed within h and Mental Hygiene. 7 is marked other than traumatic event, the Me	Be C	17. Father's Name (First, Middle, Last) William Lee Jones	Martha	(First, Middle, Maid	den Surname)	
<u> </u>	shoul	ဥ		ddress (Street and Number or Run		ty or Town, State, Z	Zip Code)
Ž	and 2 raith a 27 is			essica Drive,			
5	of He		20a. Method of Disposition 1 ■ Surial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, cremator	n (Name of [ory or other place)	Date 20c	Location - City or	Town, State
	Pag tment tant: I		4 □ Donation 5 □ Other (Specify) Maryland		30/07 I	aurel,	Maryland
פֿם	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		Health It H	ame and Address of Facility [ackett's Fune 14 Upshur Str	ral Chap	el, Inc	! •
			23a. Ant1. Exter the disease, or complications that caus. If the death. Do not enter the hock, or heart failure. List only one cause on each line.	ne mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician	Ш	Immediate Cause (Final disease or condition resulting in death) Sepsis				Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
h	- A-	er	Sequentially list conditions, if any, leading to immediate b. Pneumonia Due to (or as a consequence of):				
	outed d ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events) Cause (Disease or injury that initiated events) Cause (Disease or Injury that initiated events)	ure			
5	icate be executed physician and s the burial-transit	Ex	resulting in death) Last Due to (or as a consequence of):				
	cate b	dical	d. <u>Metastatic Endo</u>	metrial Cance	r		
S	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			004 8-4-44	
ב	death atten	Physician/Me	in the past 12 months?	topic pregnancy her (specify)		23d. Date of deli Month	Day Year
į	t the c by the achec	hysi	1 UYes 2 No 4 Pregnant at time of death 5 U Off				
'n	w requires that the d been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
5	require	ted	Malignant Ascites		1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
ב	e 2 st	Completed	Thrombocytopenia		24a. Was an autopsy	prior to d	topsy findings available completion of cause of
<u> </u>	The icate r, pag				performed 1□ Yes 2□		2 □ No
>	Physician: r this certifica ral director, p) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: IX Inpatient 2 ☐ ER/Outpatient 3	Othor	n (Check only one)		
5	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	4 Nursing Ho	me 5 Residence 28d. Describe how in		cify)
5	ath. ar: Aft	atio	Z L / VOOI OCH	M 1 Yes 2 No			
2	or Attending Physician: The lavaler death. Director: After this certificate has in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, St		ıral Route Number,
ב	pltal o		200 Codifier 4 Contifuing Physicians To the head of multi-valued doubt				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	fedical	29a. Certifier (Check only one) 1 **Medical Examiner: On the basis of examination and/or invest and manner stated.	tigation, in my opinion, death occur	red at the time, date	and place, and due	e to the cause(s)
	Viti Viti	M	29b. Signature and title of certifier	29c. License number D64189	29d. 1	Date signed (Mont) 0/22/07	h, Day, Year)
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin Dr Rama Kapoor, m.D. 1500 Fores		s., Md.	20910	
	Sta Registr		31. Date filed (Month Car Year) 5 2007				
				AND PRINCIPLES			

			1 = For State Registrar	State of Mar		artment of rtificate o			leg. No.	35910
	Physici		1. Decedent's Name (First, Middle, Last, Lewis H. Kelly					2. Date of Dea Month	Dey Year	
	/Medic Examir		4a. Fecility Neme (If not institution, give	street and number)		4b. City, Town	, or Location of D		4c. County of De	
			Coastal Hospice At	The Lake		Salis	bury		Wicomi	
н	Funeral		5. Social Security Number 6. Sec 214–30–4118	7. Age ('In yrs. last birthday) 7 Yrs.	If Under 1 Yes Months Day		Min. (Month, Day	9. B	irthplece (State or Foreign Country)
	Director		Usuel Residence of Decedent	,,,				3/6/193	30 M	aryland
	rylan		10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f e	cto	Maryland Wicomic	0	Mardela					1 Tes 2 No
	death with the Maryland ma 23s or 28s-f ehow	Funeral Director	10e. Street and Number 10248 Riverton R	oad.		10f. Zip Code 218.			10g. Citizen of What 0	Country?
	death na 23	eral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.			? (Specify Yes or No- querto Rican, etc.)		nerican Indian,
9	after dea or Itama maner mi		1 Never Married 2 Marned	Armed Forces?		If Yes, specify Ci 1 ☐ Yes 2 🔀 N		uerto Rican, etc.)		
003	72 hours after naturel', or Ita	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:						white
21215-0036	n 72 l nat	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	cupation ne during most of ired)	working	16b. Kind of Busines	s/industry
212	J within piene. r then "	mo duo	Elementary/Secondary (0-12)	College (1-4or 5+)	farm		,		agricultu	ıre
	al Hyg	BeC	17. Father's Name (First, Middle, Last)	_				Name (First, Middle,	Maiden Sumame)	
yla	2 should be filed withir and Mental Hygiene. is marked other then sumatic event, Iza M	2	Lewis Harman Kell					l A. Stewa		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Itlam 27 is marked other then "naturel", or Itama 23s or 28s-1 ehow other traumatic event, tra Medical Example from the notified at		19a. Informant's Name/Relationship (Ty Larry W. Kelly/so	•		_		or Rural Route Numbe airfax Sta		
	Healt Healt tam 2 other		20a. Method of Disposition	11	20b. Place of Dispo	sition (Name of		Date	20c. Location - City of	
ē	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Salisbury	matory or other p 7 Cremat	·	0/23/07	Salisbury	, MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 ii eny injury or other tra <u>once.</u>		21. Signature of Funeral Service Licens	•	o Ĥ	ON TOUR	Funeral	Home Prof	essional A	Association
-	20E 2 9		Jerlo 11 h	persey (K	.] / 5	Ol Snow	Hill Rd	., Salisbu	ry, MD 218	304
	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	tatic L	er the mode of d	dying, such as car		rest,	Approximate Interval Between Onset and Death
	Examiner			Due to (or as a c	consequence or):	U				
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a c	consequence of):					
	tte be executed tysician and ne burial-transit	тах	that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
8760,	0 % 0	cai		1						
9			IF FEMALE:							
Box	death certifics e attending ph d for use as th	lan/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1□Live birth 2 [Fetal death 3	Ectopic pregnar			23d. Date of d	lelivery Day Year
0	the de	ysic	1 Yes 2 No	4□Pregnant at tim 9□ Unknown	ne of death 5L	Other (specify)				
<u>α</u>	uires that the dei signed by the a Id be detached f	by Physician/Med	Part II. Other significant conditions cor	tributing to death but r	not resulting in the u	nderlying cause	given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records,	law requires as been sign 2 should be							_ 7SY	es 2 No 3	Probably 4 Unknown
ecc	law ri las be	Completed						24a. Was a	sy prior to	autopsy findings available completion of cause of
E B	: The law cate has page 2;	Col						perfor 1 ☐ Yes	med! death' 22 No 1 ☐ Ye	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	- Electric)ther	Death (Check only di		
o	Phys er this eral dia	n: To	1 Yes No 27. Manner o Death	28a. ate of Injury	2 ER/Outpatier 28b. Time of	II JU DOV	4 🗀 140121	ng Home 5 Resid	ence 6 LOther (Sp ow injury occurred	Decity)
ion	Attending I r death. actor: After by the funer	atio	Natural 5 Pending investigation	(Month, Day Y	'ear) Injury		vork? □Yes 2□No			
Division	it or Attendi after death. Diractor: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str 'Specify)	eet, factory, offic	28	28f. Location (S City or Tow	treet and Number or . n, State)	Rural Route Number,
	pitat o	Ce	29a. Certifier Certifying Phys	sician: To the best of r	mu knawladan daat	h convered at the	time data and a	lace and due to the o		an atatad
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only one) Medical Exami	ner: On the basis of ex and manner stated	camination and/or in	vestigation, in my	y opinion, death o	occurred at the time, o	late and place, and d	ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	nM	-	29c. Lice	ense number		29d. Date signed (Mo	
	. ^		THE E	LA,	CM		262	78	10-22	-0)
(E MY		30. Name and address of person who co	impleted cause of deat	th (Item 23a) (Type,	Print)	Ox R.	ר כינו	(.)	21802
9	Sta	to.	31. Date filed (Month, Day, Year)	32. Resistrar's	Signature.	pre 1	100X /	155 00	1154 10113	1000
	Registr		31. Date filed (Month, Day Year) OCT 2.5 20	107	. H. A	berle				

Physician /Medical **Examiner**

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any luly or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

Physician /Medical Examiner

The law requires that the death certificate be executed and burial-trai attending physician for use as the buria as the ed by the a been signed be should be det s certificate has b lirector, page 2 s or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Hospital

1. Decedent's Name (First, Middle, Last) 15:33 2007 October 22, Ernest Porter Koontz 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Days 1**X** M 2□ F 577-92-9671 45 June 2, 1962 Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MDMontgomery Silver Spring 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3002 Dawson Avenue 20902 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 27 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Actor/Singer Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Koontz Harriett Boettger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 Melanie Koontz/Wife 3002 Dawson Ave., Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Howard University MedOct. 24, 07 Washington, DC 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Full Parallel 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street, NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Do not enter the mow of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a co Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Usease or Injury that initiated events resulting in death) Last Examine Due to (or as à co Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 💢 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 ∏Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1☐ Yes 2☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No P 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll AVe. Takoma Park, MD Dr. Kangoo 20912

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) 0CT 25

2007

egistrar's Signature

			1 - For Amend Item 20a,26	of Maryland /	/ Depa	rtment of H	lealth an	nd Mental Hyg hb	iene eg. No2 0 0 7	35912
à.			Decedent's Name (First, Middle, Last)			timodito or i		2. Date of Dear		3. Time of Death
	Physici /Medic		Alice Cubbage	Kontz				October	30 2007	10:40A M
	Examin	er	4a. Facility Name (If not institution, give street and r	umber)		4b. City, Town, or	r Location of D	Death	4c. County of Dea	th
			126 Divern St.	T= 4 - 0	11:41 1 1		neytow		Carr	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	**	If Under 1 Year Months Days		Min. (Month, Day	Year) 9. Bir	thplace (State or Foreign ountry) t Virginia
Ž.	Director		Usual Residence of Decedent	07				Jun.22,	1943 Wes	t Virginia
	land t		10a. State 10b. County	10c. City, To	own or Loc	cation				10d. Inside City Limits
	Mary f sho	ō	Maryland Carroll			Mostm	inster			1 XYes 2 ☐ No
	the 28a notif	Directo	10e. Street and Number			10f. Zip Code	iiiistei		0g. Citizen of What Co	ountry?
	3a or		225 Frock Dr., Apt. 30	06			21157		U.S.	٨
	ms 2:	Funeral	11 Marital Status 12. Was De	cedent Ever in U.S.	13. V	Vas Decedent of H		n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame	erican Indian,
"	r iter	Ē	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	2 🔀 No				uerto Rican, etc.)	Black, Whit	e, etc.
93	urs a al", o Exan	ð	3 Widowed 4 □ Divorced If Yes, 0	aive Dates:	1	□Yes 2XINo	Specify:		Specify: Wh	nite
9	72 hours after death with the Maryland 'natural', or items 23a or 23a-f show dical Examiner must be notified at	ted	15. Decedent's Education (Specify only highest grade completed		6a. Deced	ent's Usual Occup	ation	f working	16b. Kind of Business	/industry
21	thin le.	ם		(1-4or 5+)	life. L	OO NOT use retired	d) -			
21	filed within Hygiene. other than "	Completed	12		1	aundry w			nealth care	center
Baltimore, Maryland 21215-0036	be ital	a	17. Father's Name (First, Middle, Last)					Name (First, Middle, I	,	
3	s 1 and 2 should f Health and Men item 27 is marke other traumatic	은	Garland Cubbage		401 14 111			lie Smallwo		
Nar			19a. Informant's Name/Relationship (Type. Print)		_			or Rural Route Number	_	Zip Code)
e,	is 1 and 2 of Health a item 27 is other trai		Howard Kontz Jr./ son 20a. Method of Disposition			ivern St		neytown, MD	20c. Location - City or	Town State
ŏ	permit. Pages 1 a Department of Hes Important: If item any Injury or othe		WT3 - 11 - 0 T - 11 - 0 T - 11	n State	etery, cren	sition (Name of natory or other place	ce)			
ţ	t. Partmer		4 Donation 5 Nother (Specify) Enton	bmentevers	green	Mem. Gar	uens i	1/3/200/	inksburg,	
Bal	permi Depa Impo any Ir		21. Signiful Foneral Service License	Den				Hartzler Fu		
			23a. Part1. Enter the disease, or complications tha	Support the death F		10 Church			or, MD 217	Approximate
			shock, or heart failure. List only one cause or	each line.	Jo not ente	er the mode of dylin	ig, such as ca	irdiac or respiratory arr	est,	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	L	My	CX				
	Examiner		Due t	o (or as a consequent	ce of): I					
le:		<u>~</u>	Sequentially list conditions, if any, leading to immediate b. Due to	o (or as a consequent	ce of):					
	rted nsit	nin.	cause. Enter Underlying	(
	be executed sician and burial-transit	Examine	that initiated events c	o (or as a consequen	ce of):					
8760,	the death certificate be executed y the attending physician and ched for use as the burial-transit	ical	d							
9	ificate g physias the	edic								
Вох	leath certific attending p	Physician/Med		utcome pf pregnancy		I=			23d. Date of de	livery
	death e atte d for	icia	in the past 12 months?	e birth 2□Fetal dea gnant at time of death		Ectopic pregnancy Other <i>(specify)</i>	/		Month	Day Year
Ö		hys	9 Unknown 9 Unk	nown						
S, D	The law requires that the de ate has been signed by the a page 2 should be detached to	by P	Part II. Other significant conditions contributing to	death but not resulting	g in the un	derlying cause giv	en in Part I.	23e. Did to	acco use contribute t	o the cause of death?
Records,	w require been sig should b							1/2 Y	es 2 No 3 P	robably 4 Dunknown
သွ	law requas been 2 should	plet						24a. Was a	n 24b. Were a	utopsy findings available
Ä	The lav	Completed						perfor	med? death? 2. No 1 ☐ Yes	completion of cause of
Vital	ician: Th certificate ector, pag	a	25. Was case referred to medical examiner?				26. Place of	Death (Check only or		
>	Physician: r this certific ral director,	To B	I Hognital	Inpatient 2 ☐ ER/	/Outpatien	t 3□ DOA Oth	er: 4 □ Nursi	ing Home 5 ☐ Reside	ence 6 Other (Spe	ecify) Son
n or	ding Physician: h. After this certification of the director,		27. Manner of Death 1 Matural 5 Pending (Matural)	e of Injury 28 onth, Day Year)	b. Time of Injury	28c. Injur Wor			ow injury occurred	
Sio	Attending r deah. ector Aftel by the fune	äţic	2 ☐ Accident investigation			M 1□	Yes 2 □ No			
Division	I or Attendation after death	Certification:	determined 200. Fld	ce of injury - At home lding, etc. <i>(Specify)</i>	, farm, stre	eet, factory, office		28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
	oital curs af									
	Hospital 24 hours a Funeral stely filled	edical	29a. Certifier (Check only one) 1 Y Certifying Physician: To t 2 Medical Examiner: On the	basis of examination	age, aeath and/or inv	estigation, in my c	me, date and opinion, death	place, and due to the co occurred at the time, o	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the Hospital or Attent within 24 hours after deat To the Funeral Director completely filled in by the	Med	29b. Signature and title of certifier	inner stated.		29c. Licens	e number	2	9d. Date signed (Mon	th, Day, Year)
	- 3 - ŏ		Vac/li	, MM		T	335		11/02/07	•
	_		30. Name and address of verson who completed ca	use of death Learn 23	a) (Tyne I			7 (110401	
	\mathcal{O}		Philip J. Kuzbarsky	1 /		ort Dr.	West	minster, M	D 21158	
	Sta	te	31. Date filed (Month, Day, Year) 32.	gistrar's Signature		م م				
	Registr	ar	NOV 0 8 2007	Melica St	19	esti)				

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 the Hospital or Attending Physician: 24 hours a Funeral L

Saltimore, Maryland 21215-0036

State

DHMH 17 Rev 1/2001

within 2.

31. Date filed (Month, Day, Year)
OCT 2 3 2007 Registrar

Medical

(Check only one)

Kelvin Mao

29b. Signature and title of certifier

Health 14999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Center Drive

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D50343

29d. Date signed (Month, Day, Year) October 19, 2007

201 Bonne, Maryland

10d. Inside City Limits 1 X Yes 2 □ No 10g. Citizen of What Country?

2007

4c. County of Death

Ken

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Specify:

2. Date of Death Month

8. Date of Birth (Month, Day, Year)

12/16/1955

USA

Sctober

16b. Kind of Business/Industry

Mentally Handicapped

White

0352 AM

Birthplace (State or Foreign Country)

DE

17. Father's Name (First, Middle, Last) Julian E. Leager, Sr.

19a. Informant's Name/Relationship (Type. Print)

June Ingersoll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Jay Leager/Brother 4619 Old Linden Hill Rd. Wilmington, DE 19808 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation 10/25/07 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

Stevensville, MD 22. Name and Address of Facility Fellows, Helfenbein & Newnam

130 Speer Rd. Chestertown, MD 21620 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Resmotory disease or condition resulting in death)

Due to (or as a consequence of) Due to (or as a consequence of):

Gram Negatire Sepsis - E. coli

Due to (or as a consequence of)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Approximate Interval Between Onset and Death

212045

Be

ဂ

Examiner

Physician/Medical

Completed by

Be

2

Certification:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

4□Pregnant at time of death

Month

23d. Date of delivery

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 ☐ Unknown

23 lbma

24a. Was an autopsy performe

Donon's Syndrome

25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clostn four Md 21620 Susan K- Ress 516 Washington

ar's Signature 31. Date filed (Month, Day, Year) 32. Regis State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Examiner Division or Vital Records, P.O. Box 68760,

the attending physician hed for use as the buria ate has been signed by page 2 should be detact spital or Attending Physician; Thours after death.
Ineral Director: After this certificate y filled in by the funeral director, pa To the Hospital or within 24 hours aff To the Funeral D

Physician

/Medical

27. Manner of Death

29a. Certifier

3 ☐ Suicide

6 ☐ Could not be

in

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1)00/7036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician OCTOBER 20 2009^{ar} Lucas 04:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Hospital Leonardtown Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) 05/16/1922 Virginia Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F 579-18-9647 Director 85 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Director X Yes 2 No Maryland Calvert Huntingtown 10e. Street and Number 10g. Citizen of What Country? 20639 USA 1715 Woodlow Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces 7
1 X Yes 2 □ No
If Yes, Give
Year or Dates: 1965-67 Black, White, etc. 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced natural Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Master Sergeant US Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucas Ellen Lucas Herbert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trains Gloria Lucas/ Wife 1715 Woodlow Ct. Huntingtown, Maryland 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 10/31/07 Cheltenham, Maryland 21. Signature of uneral Service Licensee 22. Name and Address of Facility Adams Funeral Home PA 19120605 Aguasco Rd. Aquasco, Maryland 20608 23a. Part1. Enter to disease, or complete that shock, or her failure. List only one cause on the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Some fields list or cities if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician P.O. Box 68760. by Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Math 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Umural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 29a. Certifier Scritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature an itle of certifier 29c. License number D0066284 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 25500 Point Lookout Rd. URC 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 5 2007 Registrar

			1 - For State of Maryland / State Registrar		tificate of I			Reg. No.	001	33310	
•	Physici /Medic		1. Depedent's Name (First, Middle, Last) MARKI	+A			2. Date of De	18	ear O7	3. Time of Death	
	Examir	er	4a. Facility Name (If not institution, give street and number) 247 Woodard Rd.		4b. City, Town, or	Location of Death			inty of Death Arun	iai	
	Funeral Director		5. Social Security Number 228-20-4610 6. Sex 1 □ M 2√F 7. Age (In yrs. last to 95)	birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Bir 9 12 Pa	th 1'9'12'	9. Birthr	place (State or Foreign	
e Maryland	tifled at	ctor	Usual Residence of Decedent 10a. State	Arno					1	0d. Inside City Limits 1 ☐ Yes 2 No	
י with th	3a or 28 st be no	Il Dire	10e. Street and Number 247 Woodard Rd.		10f. Zip Code	012		0g. Citizen of What Country? USA			
stryiailly 21213-0030 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XXNo If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes ※XX No Specify:			14.	Race - Americ Black, White,		
1.0-1 hin 72 ho	n "natur Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Ba. Deced (Give I life. E	ent's Usual Occup kind of work done of OO NOT use retired	ation during most of work f)	ing	16b. Kind o	of Business/In	dustry	
ed with	ygrene her tha t, the	Com	1	Se	cretary					vernment	
uld be fil	vental nurked oth	To Be	17. Father's Name (First, Middle, Last) Samuel Jefferson Highsmith			18. Mother's Name		, Maiden Sur	name)		
and 2 sho	ann and r	•				and Number or Run • Arnold			wn, State, Zip	Code)	
Dallillore	ant: If item ary or oth			Lawn	sition (Name of natory or other place Memorial	10/2	9/2007	Ralei			
permit.	Importa any inju		21. Signature of Funeral Service Licensee			ss of Facility Har Ave. An	-			, P.A.	
/N Ex	ysician Medical aminer	Examiner	23a. Part1. Enter the disease, of complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	pe off:	preu	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
do do,	g physician and as the burial-transit		resulting in death) Last C. Due to (or as a consequence	e of):	170				,)	
rtificat		Medical	IF FEMALE:								
The law requires that the death cer	oy the attendi ached for use	Physician//	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 🗌	Ectopic pregnancy Other (specify)	′		23d.	Date of deliv Month	ery Day Ye <i>a</i> r	
law requires tha	n signed l	by	Part II. Other significant conditions contributing to death but not resulting	j in the un	derlying cause give	en in Part I.			o use contribute to the cause of death? 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Muknown} \)		
	within 24 nours after dear. After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Completed					1□ Yes	psy ormed? 2 No	prior to co death?	opsy findings available impletion of cause of 2 No	
VILGI ysician:	s certii directo	o Be	25. Was case referred to medical examiner? 1 Yes No Hospital: 1 Inpatient 2 FR/0	Outpatient	t 3 DOA Oth	26. Place of Deatler: 4 □ Nursing Ho			Other (Speci	fv)	
Attending Physician:	n. After thi funeral	-	27. Manner of Death 1	b. Time of Injury	28c. Injur Worl	y at	28d. Describe			<i>7/</i>	
I or Attending	aner deal I Director d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office			Street and N wn, State)	umber or Run	al Route Number,	
To the Hospital or	within 24 nours arier deam. To the Funeral Director: After this completely filled in by the funeral di	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled and manner stated.	ige, death and/or inv	occurred at the tire tire tire tire occurred at the	me, date and place, ppinion, death occur	and due to the red at the time	cause(s) and , date and pla	d manner as s ice, and due t	stated. o the cause(s)	
Toth	To th comp	Me	29b. Signature and title of centier dental	M	29c. Licens	21438		Oci	gned (Month,	2007	
	60		30. Name and address of person who completed cause of death (Item 23a	450	Print) PEPENSE	HAHN	ay An	NAPO	ilis M	D21401	
ų,	Sta Registi		31. Date filed (Month, Day, Year) 32. Pegistrar's Signature 0CT 2 3 2007	de	made						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** October 17, 2007 A^{M} 7:17 Constance E. Minnigh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2477 Red Fall Court Gambrills Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Y) Feb. 26, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days 1 □ M 2 🛛 F 1920 Pennsylvania 87 Director 162-12-8924 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show Examiner must be notified at 1 XYes 2 No Director Maryland Anne Arundel Gambrills 28a-f 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? or than "natural", or Items 23a the Medical Examiner must b 21054 USA 2477 Red Fall Court by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: White Specify 3K Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any Injury or other traumatic event. the Me Elementary/Secondary (0-12) College (1-4or 5+) P.G. General Hospital Medical Records Librarian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norman Steele Susan Mary Dickson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2477 Red Fall Court Gambrills, MD 21054 Paul N. Minnigh/ Son 20b. Place of Disposition (Name of cometery, crematory or other place)
Maryland
Veterans Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 10/22/2007 4 □ Donation 5 □ Other (Specify) Cheltenham, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Honot Failure **Physician** Congestive disease or condition resulting in death) 5419 /Medical Due to (or v a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the critical Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 ☐ Other (specify) 4 Pregnant at time of death ed by the 9 Unknown 9 ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2☐No certificate has or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Curunt1 uny 30. Name and address of person who complete Jouse of death (Item 23a) (Type, Print) 4201 Mitchellville Rd Bowie MD 20716 31. Date filed (Month, Day, Year Lavanag egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCT 2 3 2007

Certificate of Death

Physician
/Medical
Examiner

death with the Maryland ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If flem 27 is marked other than "ne any Injury or other traumatic event at any Injury or other traumatic event at a once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

anding physician and use as the burial-tran y the attending p detached page 2 To the Hospital or Attending Physician: completely filled in by the funeral director, After this after death

Division or Vital Records, P.O. Box 68760

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 2007 Alexander McKay A^{M} 03:48 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Cîty, Town, or Location of Death 1413 Hunting Wood Road Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Min Months Hours 1**X** M 2□ F Yrs Director 72 02/10/1935 New York 577-44-0218 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Tyes 2 ANo Funeral Director Maryland | Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21403 United States 1413 Hunting Wood Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Painting Contractor Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernice Paris Alexander McKay, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charmaine E. Reesch/Sister 1413 Hunting Wood Road, Annapolis, Maryland 21403 20a. Method of Disposition
1 ☐ Burial 24☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 Other (Specify) Kalas Crematory 10/20/2007 Edgewater, Maryland George P. Kalas Funeral Home Funeral Service Licensee 22. Name and Address of Facility Mul 2973 Solomons Island Rd., Edgewater, MD 21037 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myelogenous disease or condition resulting in death) Due to (or as a consequence of): Myclomorocytic MAMC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only on anu Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence မ 1 ☐ Yes 2 ER/Outpatient 3□ DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural Injury 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurate. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DS2830 Ctober wen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Rad #30, Annepolis

DHMH 17 Rev 1/2001

Registrar

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Year)

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within 24 hours a

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Ex	amine	er	4a. Fecility Name (If not institution, give Randolph Hills N			1_	Location of Deat	n		Ounty of Death	
Fun	eral		Social Security Number 6. Se	7. Age (In yrs.		Wheaton If Under 1 Year	If Under 24 Hrs. Hours Min.		n	Montgo 9. Birth	mery place (State or Foreign intry)
Dire			256-08-7778	□ M 2 □ 3F 101	Yrs.	Months Days	Hours Min.	June 21		_	th Carolina
land	=	}	Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loca	ation					10d. Inside City Limits
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ith the or 284	9	Sire.	10e. Street end Number		meacon	10f. Zip Code			10g. Citize	n of What Cou	untry?
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ter de	Control	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ★No	.S. 13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puerl	Specify Yes or No- to Rican, etc.)	14	. Race - Amer Black, White	, etc.
ours al	Exe	2	3 ₩Widowed 4 Divorced	If Yes, Give Year or Dates:	10	☐ Yes 2 No	Specify:		S	pecny.	frican erican
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uld be fits Mental Hy rrked oth	tic •	10 B	Issac Johnson				Ella F	rances H	ussey	,	
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C, R	thert	-	Rubye M. Stevens 20a. Method of Disposition		Place of Disposit		ce Upper	Marlbor		20//4	
DENLITIOTE, MICT YIGHTO A 12.13-0030 permit. Pages 1 end 2 should be liled within 72 hours after death with the Marylan Departmant of Health and Mental Hygiene. Important: if item 27 ie marked other then "natural; or iteme 23s or 28e-1 show	yoro		1 Durial 2 Cremation 3 ☐ 4 Donetion 5 Other (Specify	Removal from State	emetery, crema	tory or other place	Cemt. 10	/27/2007		bbins,	
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ath cer tendin	or use	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta	il death 3 □E	Ectopic pregnancy	,		23	d. Date of deli	very Day Year
COLOS, F.O. DOX OR W requires that the death certifica been signed by the attending ph	peq:	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of c 9□Unknown	leath 5□(Other (specify)					ou, ou
s that	e deta	by Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the und	derlying cause giv	en in Part I.	23e. Did to	bacco use	e contribute to	the cause of death?
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Attending ar death. ector: Atte	the fun	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		k? Yes 2 □ No				
or Attu	n by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of fnjury - At h building, etc. (Special	ome, farm, streety)	et, factory, office		28f. Location (S City or Tow		Number or Ru	ral Route Number,
To the Hospital or Attends within 24 hours effer death. To the Funeral Director: A	completely filled in by		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wiedne death	occurred at the ein	ne date and place	a and due to the	cauce/c\ -	nd manner an	stated
ne Hos	ofetely	Medicai	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	ation and/or inve	estigation, in my o	pinion, death occi	urred at the time,	date and p	lace, and due	to the cause(s)
To the To the	COM	ž	29b. Signature and title of certifier	0 0		29c. Licens				signed (Month	
. In)		Wellan K	Kegal	Jour	/ D522	26		Octo	ber 24	, 2007
4	/		30. Name and address of person who	/ 1	/		nseina M	D 20006			
	Sta	te	Alan R. Segal, M. 31. Day (12.17)	32. Registrar's Sign	one of	orraer 2	bring, M	ע 20906_			
P.	egistr:		ULI & U 2001	Deserve D. P.	The same						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elizabeth Marsh 8:25A.M. 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) Aug. 25, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Year Days Hours 1 ☐ M 2 ☑ F 215-40-1667 88 1919 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a State 10d Inside City Limits Anne Arundel Pasadena 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 Pleasantview Avenue 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse South Baltimore Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Luckett Gertrude Roebaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eldin E. Marsh/Son 9203 Goose Pond Drive Pasadena, MD 21122 Oct. 23, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility Unaral Service Licensee Barranco & 495 Gov. R Sons P.A. Severna Park Funeral H Severna Park, MD 21146 Ritchie Hwy. 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UNOM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (a as a consequence of): 210°T IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 3 □ DOA 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) ath 27. Manner of 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pendina investigation M 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f shormust be notified at

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Certification:

29b. Signature and title of certifier

MD

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Health a

Department of Important: If it any Injury or conce.

Physician

/Medical

attending physician and for use as the burial-transit

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Baltimore, Maryland 21215-0036

within 24 hours a To the Funeral I Medical Registrar

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and manner stated

29c. License number

29d. Date signed (Month, Day, Year) 290 /

person who completed caus of death (1em 23a) (Type, Print) 30 Name and add Colon Surme.

State of Maryland / Department of Health and Mental Hygiene 200735921 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Oct. 21, D2007 **Physician** 11:24 ам Mordaunt Lena Mae /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1213 Cresthaven Drive Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🖾 F Yrs 73 Michigan 369-32-6675 February 3,1934 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. Count ehow must be notified at 1 ☐ Yes 2 ☑ No Directo Silver Spring Maryland 28a-1 Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 238 20903 U.S.A. 1213 Cresthaven Drive Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status r then "naturel", or iten the Medical Examiner Pages 1 end 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 ts marked other then "naturel", or Ite ury or other treumetic event. the Medical Examines 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: ۾ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lile. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Office Worker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Arthur Alonzo Gruesbeck Cordelia Peet ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas Mordaunt - Husband 1213 Cresthaven Drive, Silver Spring, Maryland 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Its any Injury or of once. 1 Burial 2 Commation 3 Permoval from State 10/27/2007 4 Dopation 5 Other (Specify) Hillcrest Memorial Garden's Owosso, Michigan 21. Signature of Pineral Privice Liv 22. Name and Address of Facility ensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Janes Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** 16 year resulting in death) /Medical Due to (or as a consequence of): Examiner S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, by Physician/Medical as the attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 2 20 No 3 Ectopic pregnancy Day Month Year ō 4□Pregnant at time of death 5 Other (specify) o the 9☐ Unknown 9 Unknowh á ۵. deta 23e. Did tobacco use contribute to the cause of death? signed Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, B 1 ☐ Yes 2 PHNo 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۵ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director; 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0051 10

Registrar

State

30. Name and address of person

31. Date filed (Month, Day, Year) CCT 2 5

1650 Orleans Street Baltimore Maryland 2123/

who completed cause of death (Item 23a) (Type, Print)

32. Rigistrar's Signature

	•	•	For Amend Ite State Registra AMEND#3, peri	em 46 Pe MD, 10/25/0	erofaM 07.DPs	arylan ,McCo	A , 83 7 Ce	24720 ertifica	Hoáh te of	ealth a Death	and M		giene Reg. No	000	17 35	92
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/M	edic	al	DOMINIC			MLAI	NO	T 41 00				10	19	20	07 7:10 A	1. M
Exa	mine	er	4a. Facility Name (If not institution Revaiss)			2100		4b. City	1	r Location o	Death	. MD	P1	County of Do	George's	
Fune	ral		5. Social Security Number	6. Sex	7. Ag		last birthday	if Unde	er 1 Year	if Under	24 Hrs.	8. Date of Bir	th	Ment 9. E	Birthplace (State or	Foreign
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the A		Director	Maryland Mon 10e. Street and Number	tgomery				10f 7	S11v	ver Spr	ring	T	10a Cit	izen of What		
3a or	3		15220 Peach Orch	ard Road				102	p o do	20905	5		rog. on		S.A.	
deatl		Funeral	11. Marital Status	12. Was I	Decedent d Forces?	Ever in U.	S. 13	Was Dec	edent of H			ecify Yes or No Rican, etc.))-	14. Race - A	merican Indian,	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Baraked other than "natural", or Items 23a or 28a-f show rainmair event the Modifus Evening most he mosting as		by Fu	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 🔼 Y	es 2∐ l	No		1 Yes		Specify:		nicari, etc.)		Black, W Specify:	White	
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Vial 12 sh hand hand rism			19a. Informant's Name/Relations	, ,								al Route Numb				
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Dermit, Pages 1 ar Department of Hea Mportant: If Item 2	1		1 ☑ Burial 2 ☐ Cremation		rom State	C	lace of Disp emetery, cre			1					or Town, State	
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			28a. Part1. Enter the disease, or shock or heart failure. List	complications th	nat caused	the death				_				pring,	Approximate Interval Betw	
Physici /Medic Examin	al er	e	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of).											Onset and D	eauı	
death certificate be executed e attending physician and of or use as the burial-transit	L	аісаі Ехашіп	d:													
the death certify the attending ched for use as		rnysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)										23d. Date of delivery Month Day Year			
w requires that been signed by should be deta	3	2	Part II. Other significant condition	1	to death bi	ut not resu Y <i>av</i>	Iting in the i	inderlying As	cause give	en in Part I.				use contribute □ No 3□	to the cause of de	eath?
e law re has bee		Completed	dementia			,	,					24a. Was		24b. Were	autopsy findings a	vailable
The ate h		5	congestive	heart	Pail	nre						autor perfo 1∐ Yes	rmed2	death	o completion of car ? es 2 No	use or
ician: Th certificate ector, paq			25. Was case ferred to medical examiner?							26. Place	of Death	Check only o				
dir ys	1	2	1 ☐ Yes 2 ☑ No				ER/Outpatie			Nu Nu	rsing Hor	ne 5□Resi	dence	6 □Other (S	pecify)	
dlng F h. After funera			27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	, (A	ate of Injui Month, Day	ry V Year)	28b. Time o Injury	of M	28c. Injun Work 1 □ '	yat ⟨? Yes 2 □ h		28d. Describe I	now injur	y occurred		
To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely illied in by the funeral	311	Certifications	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Pi	iace of inju uilding, etc	ury - At hor c. (Specify	me, farm, st					28f. Location (8 City or Tov	Street an vn, State	nd Number or	Rural Route Numb	er,
he Hospl in 24 hour he Funer	Toolbo	enical	29a. Certifier 1i Certifyin (Check only one) 2 ☐ Medical I	g Physician: To Examiner: On th and n	the best one basis of manner sta	examinati	vledge, dea ion and/or i	th occurred nvestigatio	at the tin n, în my o	ne, date an pinion, dea	nd place, a	and due to the ed at the time,	cause(s) date and	and manner d place, and o	as stated. lue to the cause(s)	
Vith With Com	M		29b. Signature and title of certifier	6				29	c. License	e number			29d. Dat	te signed (Mo	onth, Day, Year)	
_3			Dachelle.	alech	on) /-	LEXIO	52V	D	4415	56		10	119/20	007	
			30. Name and address of person			eath (item			(-11	· ·			_		
e B	State		PACHELLE AL 31. Date filed (Month Pay Year)	EXION	MD 2. Poistra	ar's Signat	ure 2110	Grade	ce ni	ela	anv	e Silv	ver	DANK	g MD	
	state istra	-	31. Date filed (Month Pay Year)	2007	Ray.	40 0	K	Land.							20904	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35923 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCTOBER 23, 9:30 A 2007 W. **MEYERS** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY COLLINGSWOOD NURSING HOME ROCKVILLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 📉 058-07-2083 94 Director APRIL 15, 1913 NEW YORK Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 XYes 2 No MARYLAND MONTGOMERY ROCKVILLE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 **IISA** 5408 MARLIN STREET filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2X No 1 Never Married 2 Married WHITE Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify à Specify. 3 Widowed 4 ☐ Divorced Completed marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL SALES CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be filt tment of Health and Mental H-tant: If item 27 Is marked oth jury or other traumatic event Be LEON WOLFSON SYLVIA REINSTEIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAMAH GRABER/DAUGHTER 5408 MARLIN STREET, ROCKVILLE, MARYLAND 20853 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State ortant: If i permit. Page Department o Important: If any Injury or JUDEAN MEMORIAL GDNS 10/25/2007 OLNEY, MARYLAND 4 Donation 5 Other (Specify) 21. Si ervice Lidensee 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter th shock, or hear e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Immediate Cause (Final **Physician** 2YEARS DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause Unious that initiated events resulting in death) Last Due to (or as a consequence of) Examiner has been signed by the attending physician and ge 2 should be detached for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. I∐Yes 2127No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, HYPERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate ha autopsy performed? ∕es 2 ☐ No 1∏ Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) Injury 1X Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month)

NATHAN, ARUNA S.,

32 Registrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

11125 ROCKVILLE PIKE, ROCKVILLE, MARYLAND

D0053615

29d. Date signed (Month, Day, Year)

OCTOBER 23, 2007

20852

			For State Registrar	tate of Mar	*	ertificate of			g. No.				
	36. 366	5	1 Decedent's Name (First, Middle, Last) 2 Date of Death									ath	
47	Physicia	NO 1	William Pohort Villiam Malle									М	
	/Medic Examin		4b City Tourn or Location of Death 4c Country of Death										
	LAGIIII		5789 Skyline Street Salisbury Wicomico										
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.				8. Date of Birth (Month, Day,	Year)	9. Birthp Coun	Birthplace (State or Foreig Country)		
54	Director		216 - 56-1239	Mary:	land								
	pu »	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inc.										
	aryla	'n	Tod. State		*						1 ☐ Yes 2∑		
	he M	Director	MD Wicomico 10e. Street and Number		Salisbu	10f. Zip Code		1	On Citizen	of What Coun	itry?		
	Mith t						1801	'	USA				
	eath	Funeral	5789 Skyline Street 11. Marital Status 12.	Was Decedent Ev	ver in U.S.	13. Was Decedent of H If Yes, specify Cubi		cify Yes or No-		Race - Americ	an Indian,		
	lter d	'n.	1 Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 X No)			Rican, etc.)	!	Black, White,	etc.		
980	urs al	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Spe	ecify: Wh	ite		
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel", or iteme 23e or 28e-f show event, the Mudical Exercities caust be coulded at	Completed	15. Decedent's Educat (Specify only highest grade of		16a. De	ecedent's Usual Occup	pation	na	16b. Kind o	of Business/Inc	dustry		
215	thin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5+) lit	e. DO NOT use retire	d)						
2	ed wi	S	12			ypesetter		(First Middle		paper			
p	tal Hydrand doth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	Killiam		name)			
Maryland	Men Men arke	2	Edward Mills	Town State 7in Code									
Nar	2 should and Mer le marke reumatic		19a. Informant's Name/Relationship (Type,	Print)		ailing Address (Street							
6	1 and 2 Health tem 27		Sandra Mills - wife			Skyline Sisposition (Name of				nd 2180 on - City or To			
Ö	ges If of H If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	oval from State	cemetery,	crematory or other pla		1		,			
Ë	t. Pa tmen tent: tjury		4 □Donation 5 □ Other (Specify)		Cremato	cy of Delma 22. Name and Addre	All the state of t	26-2007_			laware		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other treumatic event, the Mudical Exam retinust be notified at once.		21. Signature of Funeral Service Licensee	Roch	0		bou	nds Fun			2.1		
	40144		220 Part Enter the disease or complica	ions that caused t	he death. Do not	705 E. Maj	in Street,	Salisb or respiratory arr	ury,	MD_2180	Approximate		
			23a. Page. Enter the disease, or complete speck, or heart failure. List only one Immediate Cause (Final	cause on each line	Э.	0 (0.10		,			Interval Betwe Onset and De		
	Physician /Medical		disease or condition resulting in death)			ASCUD					7		
	Examiner			Due to (or as a	consequence of)								
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			-							
	ansit	E in	cause. Enter Underlying Cause (Disease or injury that initiated events										
Ć,	execting and and ial-tra	Examiner	resulting in death) Last										
68760,	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	ledicai	d										
	tifica ng ph as th	Vedi	15.551.11.5										
Вох	th cer endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 23c		23d	. Date of deliv Month	ery Day Ye	ar					
. 8	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at t 9 Unknown		5 Other (specify)				NOTE	Day 10		
P.O.	at the	Ph	9 Unknown		44		una ia Basti	23e Did to	hacco use	contribute to t	he cause of dea	ath?	
	res th igned be d	Ď	Part II. Other significant conditions contri	ord Oke	4	ne underlying cause gr	yen in Parti.	1 □ Y	1		bably 4 ∐Un		
Vital Records,	w require been sig should b	Completed		7100 O12	31110			-					
ec	e law has b	npidu						24a. Was autop perfor	an 2 sy med2	prior to co death?	opsy findings av ompletion of cau	ise of	
M F		S						1 ☐ Yes	2 00	1 🗌 Yes	2 No		
Vita	sicien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	spital:		_ Ot	her:			70			
	Phys this al dii	To.	27. Manner of Death	1 Inpatier 28a. Date of Injury		atient 3L DOA	4 Nursing no	me 5 Resid			Ty)		
Division of	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day		ury Wo	ork? Yes 2 No						
İSİ	deat ctor: y the	fica	3 Suicide 6 Could not be			n, street, factory, office		28f. Location (S		lumber or Rur	al Route Numbe	θ/,	
Ö	after Dire	Certification:	4 Homicide	building, etc	. (Specify)			City or Tow	m, State)				
	Hospitel or Attending 14 hours after death. Funerel Director: After tely filled in by the fune		29a. Certifier 1 Certifying Physic	ian: To the best o	f my knowledge,	death occurred at the t	ime, date and place,	and due to the	cause(s) an	d manner as	stated.		
	To the Hospitel or Attanding is within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medicai	(Check only 2 Medical Examine one)	and manner sta	ted.				_				
	To the within 2 To the complet	Σ	29b. Signature and the of certifier			29c. Licen	se number			igned (Month	1 -		
	0		, Com			}	42049	,	10	1/26	101		
	344		30. Name and address of person who com	plotoe cause of de	eath (Item 23a) (T	ype, Print)	<>	< .	lich	1. 1/	N 518	01	
			31. Date filed (Month, Day, Year)	N 32. ■eqistra	r's Signature	Convoll Convoll	3),	٥٩	,112.M	7			
1	St Regist	ate rar	OCT 2 6 2007	1000	J #	barle							
			001 ~ 0 2001	Jane	/	/							

State Registrar

MD 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mession

29b. Signature and title of certifier

3110 32. Rejistrar's Signature

29c. License number

D44156

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10 CTHEL NELSON-KERRICK /Medical **Examiner** 75 CARVER EDGEWATER ANNE ARUNDEZ If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 Director 21 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Yes 2 No Director EDGEWATER 10e. Street and Number 10g. Citizen of What Country? 21037 4175 PARVEL by Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑ Yes 2 □ No Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes No Maryland 21215-0036 Specify: BLACK 3 Widowed 4 □ Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) KOGISTERED permit. Pages 1 and 2 should be filed very be partment of Health and Mental Hygis Important: If Item 27 is marked other. injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21037 19a. Informant's Name/Relationship (Type. Print) CARVEL TAYMON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Descript 2 Cremation 3 Removal from State 4 Donatton 5 Other (Specify) 27/07 SUITLAND MD Lincoln 22. Name and Address of Facility TOHNT Rhines Fungral Home Signature of Funeral any WASH, D.C. 2001 Part1. Enter the disease, or coor shock, or heart failure. List only mediate Cause (Final **Physician** olon 26-105 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran and Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Por Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Probably 4 ☐Unknown Completed scular Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate Division or Vital 26. Place of Death (Check only one 25. Was case referred to medical Be examiner? Other: 4 Nursing Home Mesidence 6 Other (Specify) 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation or Attending Natural
Accident Injury 1 ☐ Yes 2 ☐ No hours after death. To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗷 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) **刀3リチ3** 30. Name and address of person who completed cause or de RAYMON K NELSON 1160 VARNUM STNE #ZO8 WASH, DCZOO17 M.D. 32. Registrar's Signa State Registrar

			For State Registrar	State of Mar		partment of Hertificate of L			iene eg. Nø? () () 7	35927
	Physici	an	1. Decedent's Name (First, Middle, Last TEHYA TIARA					Date of Deat Month OCT - 1	th Day Year .9 2007	3. Time of Death 7:27 A
н	/Medic		4a. Facility Name (If not institution, give	PERSON street and number)		4b. City, Town, or	Location of Death	001. 1	4c. County of Dea	
	Examin	er	SOUTHERN MARYI		TAL	CL	INTON			GEORGES
	Funeral		Social Security Number 6. S		In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign punitry) RYLAND
	Director		N/A	□M 2[X]F	Yrs.		10	10/19/	07 MA	KILAND
	and and		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, Town or	Location				10d. Inside City Limits
	Maryl -f sho lied	ţ	MD PG		OXON I	HILL				14 Yes 2 □ No
	h the	lec	10e. Street and Number			10f. Zip Code		1	log. Citizen of What Co	ountry?
	th wit	aD	1435 SOUTHERN	AVE. #P3		20745			U.S.A	
36	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show Jeal Examiner must be natified at	by Funeral Director	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2★2★30 If Yes, Give Year or Dates:	er in U.S. 13	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐KNo	ispanic Origin? (Spec in, Mexican, Puerto P Specity:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	te, etc.
Š	72 hours "natural",	ted	15. Decedent's Ed	ucation	16a. Dec	cedent's Usual Occup	ation	70	16b. Kind of Business	/Industry
21215-0036	d within 72 hours piene. r than "natural", its Nacion Ex-	Jple.	(Specify only highest gra	College (1-4or 5+)	life	ve kind of work done of . DO NOT use retired . N / A	during most of working	'9	N/A	
7	filed will Hygien other th	Completed	0			N/A	18. Mother's Name	/First Adiabatic		
ğ	ld be filed iental Hygi ked other ic evant, I	Be	17. Father's Name (First, Middle, Last) TRAVONE PERSON					OLE ST		
Maryland	∑ 2 2 2	ပ္	19a. Informant's Name/Relationship	Type Print)	19h Ma	iling Address (Street)			r, City or Town, State,	Zip Code)
Ma	nd 2 shoulth and 27 is m	P (NICOLE STEVENS	**. *		-				MD 20745
	t and the Health tram 27 other tr		20a. Method of Disposition			position (Name of rematory or other place		ate	20c. Location - City or	Town, State
Ę	o ○ <u>+</u> =		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)			EAKE CRE		3/07	BELTSVI	LLE, MD
Baltimore,	permit. Pag Department Importent::I any injury o		21. Signature of Funeral Service Licer	See .						AL SERVICE
<u> </u>	89 5 8		23a. Part 1. Enter the disease, of com shock, or hear failure. List only	Stewart						GS, MD, 207
8760,	In page 2 of the provided of the price of th	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Presto (or as a	consequence of):	Jeannt	al Seps	515		
P.O. Box 68	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	,		23d. Date of de Month	elivery Day Year
	es that thing the second of the detaction of the detaction of the second	by Pt	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bbacco use contribute	
ğ	w require been sig should b							1 🗆 Y	′es 2.27No 3F	Probably 4 Unknown
Vital Records,	The lar ate has page 2	Completed							rmed2 prior to	autopsy findings available completion of cause of s
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	-5	iont 3 DOA Oth	26. Place of Death			
of	ding h. After fune	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day		of 28c. Injur	y at 2		dence 6 □Other (Sp now injury occurred	өспу)
Division	F ¥ te	Certification:	3 Suicide 6 Could not be determined		y - At home, farm, (Specify)	street, factory, office	2	28f. Location (5 City or Tow	Street and Number or F vn, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exact	nysicien: To the best of niner: On the basis of a and manner state	examination and/o	eath occurred at the tir investigation, in my o	me, date and place, a ppinion, death occurre	and due to the ded at the time, d	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	1		29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)
1			> Ver	1		00	063068	8	10/19	107
			30. Name and address of person who	completed cause of de-	ath (Item 23a) (Typ	oe, Print)				
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	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 5 2007	32. Registrar	s signauite	Ĩ			•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician OSKO 0 2007 20 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dix Fernosa if Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) June 30, 1927 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. 80 New York Director 215-22-3403 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location Severna Park 10a. State 10b. County Anne Arundel MD 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21146 419 Fernwood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. White ģ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Hartford Carroll Frink, Sr. ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3807 Cedarbrooke Place, Baltimore, MD 21236 19a. Informant's Name/Relationship (Type. Print) Catherine A. Dietz/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Oct. 24, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD Maryland Veterans Cemetery 2007 4 Donation 5 Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Fineral Service Licenses 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on part line. immediate Cause (Final disease or condition resulting in death) anar **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 ☐ Fetal dea 4 Pregnant at time of death 2 Fetal death in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3E/No 3 Probabiy 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? es 2 No 2210 certificate 1□ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) ို After this i fler death.
ii Director After this
id in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural Injury 5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funerai Medical (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29

State Registrar Bestyle Ri

32. Registrar's Signature

31. Date filed (Month, Day, Year) OCT 2 4 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sure 300 Annapis MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Thelma F. 0343 October 2007 /Medical 21 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hosptial Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🕇 F 248-66-4968 67 Director 02/24/1940 South Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Germantown Md 1 XYes 2 No Funeral Director Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21106 Tall Cedar Lane 20876 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Black Specify Completed by 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Private Industry 2years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Fulton Hester Martin ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Tammy Williams (Daughter) 7523 Augustine way Gaitherburg Md.20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt.Zero Cemetery 10/25/2007 Manning South Carol 4 Donation 5 Dother (Specify) 21. Signature of Juneral Service 22. Name and Address of Facility ensee 20011 Tyrone J. Young 719 Kennedy St. NW WashDC 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pue to (or as a consequence of): Heart Failure minutes resulting in death) /Medical **Examiner** Due to do a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Wichetes Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 300 1☐ Yes 2 D No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No Certification: To 1 Inpatient 2 ★R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or A...
And 24 hours after death.
Arall Director: After in the fur 5 ☐ Pending investigation Injury 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) leburah Sherrill 9901 Medical Center Dr. Rockville, mp 20850 31. Date filed (Month, Day, Year)
OCT 2 5 2007 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 35930 Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 12:05 A M BEVERLY RAWLS-LASSITER October | 19, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery WASHINGTON ADVENTIST HOSPITAL Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/10/1953 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 54 1 ☐ M 2 🖸 F 097-46-2831 Washington, DC Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show the Medical Examiner nast by notified at X□Yes 2□No DC N/A Director Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1941 Naylor Road, SE #8 20020 United States by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Iteme 11. Marital Status filed within 72 hours after Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced "netural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Accountant Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peges 1 and 2 should be fit ment of Health and Mental H lant: If Item 27 is marked of Unknown Mildred Rawls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlton Lassiter/Husband 1941 Naylor Road, SE #8, Washington, DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 Normation 3 □ Removal from State 6 10/27/2007 permit. Pege Department of Important: if any injury or once. Metropolitan Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signatura of Funeral Service Licente 22. Name and Address of Facility Pope Funeral Homes, P.A. 2617 Pennsylvania Ave., SE, Washington, DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ceresyo Vascales /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 (1) NO 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Certification; To Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA erel Director: After thi filled in by the funeral 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 LaNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined. 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel L Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 0060100

State Registrar

Silverspr 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAGMINA K AGMED, MD

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31. Date filed (Month Day Year OCT 2 5 2007

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ore,	of He fitem		20a. Method of Disp		☐Removal from State	20b. P	lace of Disponentery, cre	osition (Name of matory or other pla	ce)	Date	20c. Lo	ocation - City or	Town, State	
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			State Registrar		Certificate of Death					Reg. No. 2007 3593			
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	/Medic			ARET ELEANOR	RATHV	/ON			October	_	2007	10:30	\mathbf{P}^{M}
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	nd 2 salth a		Kathryn Dowling	/ Daughter		13333	3 Graceha	am Road, '	Thurmont	, Ma	ryland :	21788	
ē,	es 1 and 2 of Health a f Item 27 is	Ì	20a. Method of Disposition		cen	ce of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Loca	ation - City or To	own, State	
E	Page nent c int; If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Blue	Rida	ge Cemete	ery 10/2	9/07 🏻 🏗	hurm	ont, Ma	ryland	
Baltimore,	permit. Pages 1 an Department of Heal Important; If item 2 any injury or other once.		21. Signature of Fyn I Service	Lio de D	20 UT	R	Name and Addre	DATLEY & MAIN ST.,	SON FUN	ERAL	HOMES,	P.A.	
	Physician		23a. Part1. Exter the disease or shock, or heart failure. List Immediate Cause (Final	complications that caused only one cause on , ach li	the leath,			ng, such as cardiac		est,	B 21700	Approximate Interval Betw Onset and Do	reen eath
7	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequer	nce of):	rana					d mi	W115
8		je je	Sequentially list conditions,	b. Clia to (or the	a consequen	one offi						you	لم
	uted 3 ansit	Examiner	Sequentially list conditions, if any, leading to limited late cause. Enter Underlying Cause (Disease or injury that initiated events									7	
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. Box	The law requires that the death certificate has been signed by the attending planage 2 should be detached for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal de	eath 3L	Ectopic pregnanc Other (specify)	су		23	3d. Date of delive Month	,	ear
Vital Records, P.O	w requires that the second of	by Ph	Part II. Other significant condition	ons contributing to death b	out not resulti	ng in the u	nderlying cause gi	ven in Part I.	23e. Did to	1	e contribute to t	he cause of de	
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ita	iclan: Th certificate rector, pag	Be	25. Was case referred to medica examiner?						th (Check only or	ne)			
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ono	Attending Physiclan: r death. ector: After this certifica	tion:	27. Manner of Death 1 Natural 5 ☐ Pendir 2 ☐ Accident investi	28a. Date of Injug (Month, Da gation	ury 2: ay Year)	8b. Time o Injury	Wo	ıryat ırk?]Yes 2∐No	28d. Describe h	ow injury	occurred		
Division or	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could 4 Homicide determ	not be lined 28e. Place of in building, e	jury - At homito. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and n, State)	Number or Run	al Route Numb	per,
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in b	Medical C		ng Physician: To the best Examiner: On the basis of and manner st	of examinatio)
	To the To the To the To the Comple	Me	29b. Signature and title of certifie	r			29c. Licen	se number			signed (Month,		
			DA1150				Do	1651	6	DC	TOBED	1 26	200-

on who completed cause PREDERICK MO

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Faye Lamb Sadler 10/22/2007 2:45a₩ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Elder Care Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/28/1917 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 T 89 234-68-0841 West Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes ANO Director Anne Arundel Arnold 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 404 Beach Rd. 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Art No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White þ 3 X Widowed 4 ☐ Divorced Be Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f Health and Mental Item 27 Is marked o Don Lamb Edith Jarrell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Sadler 404 Beach Rd. Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6 1 ☑ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important; If any injury or 10/26/2007 Montgomery Cemetery 4 Donation 5 Other (Specify) London, West Virginia 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Jahr 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STROKE WEEK /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death use 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? page 1 ☐ Yes 2∏ No 1□ Yes 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Knursing Home 5 Residence 6 Other (Specify) 2 No 3□ DOA 1 ☐ Yes 2 ER/Outpatient this 24 hours after death.

e Funeral Director: After thioletely filled in by the funeral. 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi and manner stated. 29b. Signature ap 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BLAN C-WALLACE, WD, 9005 KILBRIDE RD, BARTMORE, MOZIZZE State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** October 21, 2007 Calvin Eugene Swanson 12:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 XM 2 ☐ F Director 168-22-6989 78 17, 1929 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County urai", or items 23a or 28a-f show | Examiner must be notified at 1 X Yes 2 No Directo Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12505 Shetland Lane 20715 USA Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates! 48- 152 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced White "natural" Il Hygiene. other than "natura rent, the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent Insurance other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 Is marked of traumatic ever Arthur Richard Swanson Mildred Dorsett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any injury or other trau once. Gloria Swanson/ Wife 12505 Shetland Lane Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 10/24/2007 4 Donation 5 Dother (Specify) Alexandria, VA Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Uncerning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Sepsis physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of rector, page 2 s 24a Was an autopsy performed?

1 Yes 2 No death? 1 ☐ Yes 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident hours after death Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in within 24 hours a To the Funeral I 29a, Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

State

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) OCT 2 3 2007

Registrar

			1 - State Registrar	ertificate of Death	Res	g. No. 200	7 25027					
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	~00	3. Time of Death					
	Physici /Medic		Pamela Cleo Stockton – Gordo	n	October	18, 2007	11:40 a ^M					
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Deat	h					
			Southern Maryland Hospital	Clinton		Prince (Georges					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hours Min.	8. Date of Birth (Month, Day,	<i>Year) C</i> o	hplace (State or Foreign untry)					
l.	Director		230-90-3333		July 29,	1957 Wel	ch, W. Va.					
	and w		Usual Residence of Decedent 10a, State 10b, County 10c. City, Town or	Location			10d. Inside City Limits					
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	the N 28a-i	Director	10e. Street and Number	ict Heights 10f. Zip Code	100	g. Citizen of What Co	untry?					
	with Sa or t be	٥	6606 Juneau Street	20747		United St						
	ns 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ame	rican Indian,					
(0	r iter	Ē	1 □ Never Married 2 Narried 1 □ Yes 2 No		o Rican, etc.)	Black, White						
8	al",o Exan	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: B1	ack					
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation	king 1	6b. Kind of Business/	Industry					
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	e filed wall Hygier other the	ပ္ပ		artment Manager Spe								
nd	be fil d oth	Be	17. Father's Name (First, Middle, Last) Celo Williams		ne <i>(First, Middle, M</i> . Bell Ha	*						
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Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at				,							
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altimore,	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) Resurre 21. Signatuse of Funeral Service Licensee	22. Name and Address of Facility	24,2007 C	Clinton, Mo	<u>. </u>					
B	Dep Imp any onc		+ Kitta O. Sunce Moloso	22. Name and Address of Facility Alexander 5.538 Mariboro Pil	kė/Forėsty	ville, Md.	20747					
į.			23a. Par 1. Firer the diseas , or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between					
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0	ng Pł fter tł neral		27. Manner of Death 1 ☑ Natural 5 □ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)		28d. Describe how	v injury occurred						
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	urs a		29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	noth accurred at the time, date and place		(2)						
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	Sta	- 11	30. Name and address of person who completed cause of death (Item 23a) (Type Roin Tan FARAHI FAR M.D. 9801 Ge 31. Date filed (Month, Pay Year) OCT 2 5 2007 Security D. Securi									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		For State Registrar	State of Ma	rylan	-	artmen rtificat			and Me		iene	200	7	359	38
Physici	an	1. Decedent's Name (First, Middle, Last)		2 -						2. Date of Deat Month	th Day	Ye		3. Time of D	
/Medic Examin		Jam 4a. Facility Name (If not institution, give s	es Willare treet and number)	d Sy	polt	4b. City,	Town, or	Location o		October		1, 200 County of D		1942	IVI
		Union Hospital 5. Social Security Number 6. Sex			ty (ast birthday)	If Under		Elktor If Under		3. Date of Birth		Q	Cec		Foreign
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3a or 2	Dir	10e. Street and Number 340 Principio Ro	ad			10f. Zip		1904		1	0g. Citize	en of What	Countr	y?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Was Decedif Yes, specification			gin? (Spec n, Puerto Ri	ify Yes or No- ican, etc.)		4. Race - A Black, V Specify:	/hite, e		
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Mary d 2 sho th and 1 7 is me traume		19a. Informant's Name/Relationship (Type Marie T. Sypolt	e.Print) (wife)			-				Route Number				•	4
or Heal		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nar.	ne of	i	Da Da	t Depos		ation - City			ŧ
Baltimore, bernit. Pages 1 ar Department of Heam poportant: If Item 2 any injury or other once.	7	1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		1	. Ferris	& Co.	, Inc		10/25	5/07 W	æst C	hester	, Pe	nnsylva	nia
Bal permi Depa Impo any ii	ļ ļ	21. Signafure of Funeral Service License	all on	NE	Le Le	e A.	Patt	s of Facilit Cerson Mary	n & S	on Fune 21903-	ral	Home	, P.	Α.	
Physician /Medical Examiner /Medical physician and physician and the prujal-transit	dical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseque	nelun	rileve nepa	4	· k-la	1000	loni e				Approximate Interval Betwi Onset and De	een eath
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Division or Vital Records, P.O. Box 6: To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Certification: 1	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Could not be determined	28a. Date of Injury (Month, Day) 28e. Place of injur building, etc.	<i>Year)</i> y - At ho	28b. Time of Injury me, farm, str	М	_		No 28	d. Describe ho if. Location (St City or Town	ow injury reet and	occurred			e <i>r</i> ,
Divisic To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	edical Co	29a. Certifier (Check only one) 112 Certifying Phys	cian: To the best of er: On the basis of and manner state	examinat	wledge, death	n occurred vestigation	at the tim	ne, date an pinion, dea	d place, ar	nd due to the cand at the time, d	ause(s) a ate and	and manne place, and	r as sta due to	ated. the cause(s)	
To th within To th	Me	29b. Signature and vittle of certifier	No. of the contract of the con	Walter Steel E. v. v.			6 O	663	27	1	9d. Date	signed (M	onth, D	ay, Year)	
6		30. Name and address of person who cou	npleted cause of dea		23a) (Type,	Print)	7251	37,	ELK	TON. 1	1	219	21		
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signa	ture L	books	1								

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Md.

Funeral

Director

within 24 hours after death To the Funeral Director: State Registrar

Hospital or Attending Physician;

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

04/4220

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29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Stevenson October 2007 -ugene /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital 120 8. Date of Birth (Month, Day, Year)
APril 14/954 Social Security Number Sex 1 M 2 ☐ F 7. Age (In yrd. last birthday) (State or Foreign **Funeral** Days 44-88-0012 Director Usual Residence of Decedent North Carolina 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Deparatment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner. 1 PYes 2 No Director MD2ambridge 10e. Street and Number 10g. Citizen of What Country? 21613 1608 USA axmore -ane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ş 3 Widowed 4 Divorced Black 1975 Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Repairer Marine Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stevenson P Magdaline Mary eveland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zif Code) Paxmore Lane Cambridge, MD. 21613 Druscillia stevenson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/29/07 Cambridge, MD 4 □ Donation 5 □ Other (Specify) Bethel Cemetery 22. Name and Address & Facility Home, P.A. 140 Washington St. Cambridge, MD. 21613 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 3425 /Medical Due to (or as a consequence of) Examiner HYPERTEN SION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit Exami that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical as the 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed CEREBROUSSURM 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan NUDUZE THYREIS 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 2 ER/Outpatient 1 Inpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 00065107 MD

State

mure ST CAMBRIDGE

503A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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trar's Signature

ADAM D. GARRETSON

31. Date filed (Month

Registrar DHMH 17 Rev 1/2001

			1 - State Amend Item RegistrateD#23a, Pt.2	ns 23aPt I,II penMD, 10/25/0	25,27,28	Jepa Ç el	intment of F	beam 6/07d	h b	gierie Reg. No.		
	Physici	an	Decedent's Name (First, Middle, La	ast)	5450004451				2. Date of Dea Month October	ith		3. Time of Death
	/Medi Examir	cal	Samuel W. Seem 4a. Facility Name (If not institution, given				4b. City, Town, o	Location of Death		-	County of Death	8:45P. M
	LXanjin	ic.	Hillhøven Assisted Lv	g.,Nursingℜ	hab Cente	er	Adelphi]	Prince G	eorge's
	Funeral Director			Sex 7. Age	e (In yrs. last bir 84	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 20,	192.	9. Birth Cou 3 Mis	place (State or Foreign ntry) SOUri
	Maryland 1-f show	tor	10a. State 10b. County Maryland Montgome	ry	10c. City, Tow Silve:							10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28a	Funeral Director	10e. Street and Number 1324 Dale Drive				10f. Zip Code 209	10	1	_	izen of What Cou ted Stat	-
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic event, the Modical Examitted is used by neithful at 2005.	by Funer	11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1	Was Decedent of H If Yes, specify Cuba I ☐ Yes 2 X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		14. Race - Ameri Black, White, Specify:	
Maryland 21215-0036	ilthin 72 ho ne. h an "natu	Completed by	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	+).			ation during most of work	king		ind of Business/Ir	dustry
22	Hygier Hygier ther th		17. Father's Name (First, Middle, Last		-4 P6	erso	onnel Exe	18. Mother's Nam	e (First Middle		ilroad	
au	lid be lental ked o ic eve	To Be	Ralph Joseph See					Mabel G			0020)	
	and 2 should salth and Mer n 27 is marke ler traumatic		19a. Informant's Name/Relationship Bruce T. Seeman					and Number or Rui				
Baltimore,	Pages 1 a lent of Hes nt: # Item ry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci		20b. Place of cemeter	f Dispo	sition (Name of natory or other place	ee)	Date	20c. Lo	ocation - City or T	
Balti	permit. Page Department Important: fl any injury o		21. Signature of Funeral Service Lice	Bagen	Self							yland 20705
Ī	13		23a. Part1. Enter the disease, or com shock, or heart failure. List only		_	not ent	or the mode of dyin	g, such as cardiac	or respiratory are	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cosol	ac Au	54	home				-	5 mix
	Examiner		Sequentially list conditions	Carel	ac Ar	re.	st		.,	(,		5 mile
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	of):	u dis	0050	. 16	TO	O. 23	15 usi
o	tificate be executed ig physicien and as the burial-transit		that initiated events resulting in death) Last	Due to (or as a	consequence	of):	4 -0.2	ease	NED BY MEDICAL	Will	2."	(3)
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.O. Box 6	ath cer ttendir or use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of 1□Live birth 24□Pregnant at 9□Unknown	of pregnancy 2 Detail death	3□	Ectopic pregnancy Other (specify)	CERTA			23d. Date of deliv Month	ery Day Year
О.	uires that the de signed by the a id be detached f	by	Part II. Other significant conditions		it not resulting in	n the ur	nderlying cause give	en in Part I.		bacco u	_	he cause of death?
Records,	The law require ate has been signage 2 should b	Completed	Congestive F left Hi		re Fai	lu:	re		24a. Was a autop perfor	sy med?	prior to co	opsy findings available impletion of cause of
Viital		Be C	25. Was case referred to medical examiner?		-91			26. Place of Deat		2 💢 No ne)	1 ☐ Yes	ZLXN0
	90 17	2	1 X Yes 2XN o	Hospital: 1 Inpatier		_		er: Wursing Ho				(y)
Division of	tending Phy death. tor: After this the funeral of	Certification;	27. Magner of Death 1 ZNAtural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	00/13/2001	Year) Unka			Yas (? Yes 2 X No	Subject	fell.		
DIX	al or Attends selter death	Sertifi	4 Homicide determined		. (Specify)		eet, factory, office		City or Tow	n, State	d Number or Run 4301 Kn	wles Ave.
	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fune	edicai	29a. Certifier (Check only one) 1 Certifying Pl	hysician: To the best o miner: On the basis of and manner stat	f my knowledge examination an	, death	occurred at the timestigation, in my or	ne, date and place,	and due to the d	ause(s)	and manner as s	stated. o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c. License		2		e signed (Month,	
	3		- Lymin	accompleted and the	anh (lt 22 · ·	CT: c=	D178	43		00	tober 22	2, 2007
			Vivek C. Vaid, M.	.D. 3311 To	oledo Te	erra	ce Hyatt	sville, M	Jaryland	207	782	
:-	Sta Registr		31. Date filed (Mont) (P) (27)5	2007 32. Figistra	r's Signature		reste					

			1- State of Maryland / De Registrar	epartment of Certificate of				5942
¢	Physici /Medic		1. Decedent's Name (First, Middle, Last) Isabel Arline Stern			2. Date of Deat October	h 3. Tir	me of Death: 34 p M
j	Examir		4a. Facility Name (If not institution, give street and number) 7314 Parkview Drive	4b. City, Town, Frederic	or Location of Dea	th	4c. County of Death Frederick	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days				
	h the Maryland or 28a-f show e notified at	Director	10e. Street and Number	r Location erick 10f. Zip Code		11		de City Limits Yes 2 No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	7314 Parkview Drive 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 1 No If Yes, Give Year or Dates:	13. Was Decedent of	ban, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	USA 14. Race - American India Black, White, etc. SpecifyWhite	ın,
Maryland 21215-0036	d within 72 ho giene. er than "natu , the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occu Give kind of work done fe. DO NOT use retin Homemaker	upation eduring most of wo ed)	orking	16b. Kind of Business/Industry Own Home	
yland	should be file and Mental Hy marked oth umatic event	To Be (17. Father's Name (First, Middle, Last) Arthur J. Trepanier		i i	me (First, Middle, M	· · · · · · · · · · · · · · · · · · ·	
	1 and 2 sho Health and em 27 is ma other trauma		Denise Shaffer/ Daughter 731	4 Parkvie		Frederic	City or Town, State, Zip Code) C, MD 21702	
altimore,	Enert of H tment of H tant: If iter		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ NOther (Specify) entombment Gate of	isposition (Name of crematory or other plants of Heaven Co		2007 Si	20c. Location - City or Town, Sta	
Ba	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	500 Unive	rsity Bly	/d, W, Si	Home Inc. Lver Spring, MD	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia		ing, such as cardia	ac or respiratory arre	Interva	ximate al Between and Death ek
8760,	Examined be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of).					
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rds, P	quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the Coronary Artery Disease, Diabetes M				es 2∑ No 3 Probably	
al Records,		Completed	Failure to Thrive, Stroke, Osteoart Osteoporosis	hritis,		24a. Was ar autops perform 1∐ Yes 2	y prior to completion	
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:		ther:	eath (Check only one		
Division or	ding Phys h. After this funeral di	tion: To	1 ☐ Yes 2 ☑ No	e of 28c. Injury	4 Li Nursing i		nce 6 □Other (Specify) w injury occurred	
Divisi	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Sulcide 6 Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)			28f. Location (St. City or Town	reet and Number or Rural Route , State)	Number,
	To the Hospital or within 24 hours afte To the Funeral Dil completely filled in	Medical (29a. Certifier (Check only one) One) Certifying Physician: To the best of my knowledge, dependent on the basis of examination and/one and manner stated. Certifying Physician: To the best of my knowledge, dependent on the basis of examination and/one and manner stated.	eath occurred at the or investigation, in my	time, date and place opinion, death occ	ce, and due to the ca curred at the time, d	ause(s) and manner as stated. ate and place, and due to the ca	use(s)
)	1	Med	29b. Signature and title of certifier		nse number 0493	29	October	
	6		30. Name and address of person who completed cause of death (Item 23a) (Ty John S. Saia, MD 1202 Seven		d, #202,	Rockville	e, MD 20854	
3	Sta Registr		31. Date filed (Mo 1017 2a 5 2007 32. Jegistrar's Signature	Societi 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 7 35943 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Oct. RUTH SMITH 23, 2007 8:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Takoma Park P.G. Sligo Creek Nursing & Rehab If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex Birthplace (State or Foreign Days Hours 1 ☐ M 2 🖫 F Yrs. 81 Director 087-56-6703 New York Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Yes 2 No Directo Md. P.G. Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20912 U.S.A. 7525 Carroll Avenue items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②CMSo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ þ 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 □ Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit.
Department of Health and Mental Hygiene important: if item 27 is marked other the any injury or other traumatic event, the ODES. Homemaker Domestic 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bertha Dukes George Mickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9201 New Hamp. Ave. Silver Spring, Md. 20903 Sharon Byrd/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 10/26/07 Riverdale, Md. * 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park 22. Name and Address of Facility
The House of Williams Fun. Svc.
814 Upshur Street, N.W. 21. Si via ure of Funeral Service Licensee el ellery 23a. fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atheroscherote Cardiovascher disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Nhknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No of Vital 1 Yes 2K No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Marsing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA P 1 Yes 2X No 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funerai I 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 10060100 10-25-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tahmina Ahmed, M.D. 831 Univ. Blvd. S.S. Md. 20903 32. Pasistrar's Signature 2°5 State 2007 13. Apartis Registrar

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene.	Important: if item 27 is marked other than "natural", or items 23a or 28a-f show	any injury or other traumatic event, the Medical Examiner must be notified at	ouce"
	death with the Marylar		этs 23a or 28a-f show	er must be notified at	

Physic /Medi Exami

Funeral Director

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

	4	For State	State of Ma	aryland / De	•			lental Hy	giene		05011	
_		Registrar 1. Decedent's Name (First, Middle, Las	-1)		Certificat	e or Dea	atn	2. Date of De	Reg. No.	2007	35944	
ician			0						23, Day	OO7 Year	7. 2 F aM	
dical		Gerard W. Smith 4a. Facility Name (If not institution, give	street and number)		4h City	Town, or Loca	ation of Death	Oct.		ounty of Deat	7:35 a ^M	
niner		1103 Schindler Di			,	er Spr				tgomery		
al		5. Social Security Number 6. Se	ex 7. Age	e (In yrs. last birtho	day) If Under	1 Year If U	Inder 24 Hrs.	8. Date of Bi	rth	9 Rint	hplace (State or Foreign	
or		192-01-6211	₽ M 2□F	93 Yrs	s. Months	Days Ho	ours Min.	May 17	, 191	4 Peni	^{uintry)} nsylvania	
	- h	Usual Residence of Decedent		40.00								
	- 1	10a. State 10b. County		10c. City, Town o	or Location						10d. Inside City Limits 1 ☐ Yes 2X No	
Director	3	MD Montgomer	су	Silver	_							
از ا		10e. Street and Number			10f. Zip					en of What Co	untry?	
2	8	1103 Schindler Di		Turn in III C		903	in Onining (0-		U.S	. A . I. Race - Ame	rican Indian	
Finaral	5	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent B Armed Forces? 1 ☐ Yes 21 1	ever in 0.5.	13. Was Dece If Yes, spe	cify Cuban, Me	exican, Puerto	Rican, etc.))-	Black, White		
2	<u>,</u>	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	40	1 🗆 Yes	Sp.	ecify:		S	pecify: Wh	ite	
2	3	15. Decedent's Ed	lucation	16a. De	ecedent's Usu	al Occupation			16b. Kind	of Business/l		
Completed	2	(Specify only highest gra	de completed) College (1-4or 5	(6)	Give kind of wo ife. DO NOT u	rk done during se retired)	g most of worki	ing	1		·	
E	5	12	College (1-40) 5	' I	chinist				U.S.	Gover	nment	
a a		17. Father's Name (First, Middle, Last)				18. 1	Mother's Name	(First, Middle	, Maiden Si			
Ę		Fred Smith										
l'		19a. Informant's Name/Relationship (7	Town, State, Z	Zip Code)								
	J.	Ella Smith/ daugh	nter		2 Breck							
J.	1	20a. Method of Disposition 1 ☐ Burial 2x☐ Cremation 3 ☐	Removal from State	20b. Place of D cemetery,	isposition (Nai crematory or o	me of other place)	-	Date	20c. Loca	ation - City or	Town, State	
		4 □ Donation 5 □ Other (Specify		Ft. Lin	coln Cr	emator	y10/29/	/2007	Brent	wood, l	MD Home, Inc.	
ouce.		21. Signature of Funeral Service Citien		-#	_ 22. Name ar	nd Address of	Facility Hine	es-Rina	ldi F	uneral	Home, Inc.	
ol		gagner	Villen	STH-						er Spr	ing, MD 2090	
		23a. P. rt1. Enter the disease, or companions shock, or he in failure. List only	one cause on each lir	the death. Do not ie.	t enter the mod	de of dying, su	ch as cardiac o	or respiratory a	ırrest,		Approximate Interval Between Onset and Death	
in		Immediate Cause (Final disease or condition resulting in death)										
al er		Testing in deadly	`	a consequence of)								
E .	,	Sequentially list conditions,	b. Prostate	e Carcino a consequence of)							15 years	
Examiner		if any, leading to immediate Cause (Disease or injury that initiated events								11		
i k	2	resulting in death) Last	C. Due to (or as	a consequence of)	:							
			-d.									
jed	3								17.7			
by Physician/Medical		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnancy 2 ☐ Fetal death	3 □Ectopic p	rognanov.			23	d. Date of deli	ivery	
100	5	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		5 ☐ Other (s _i					Month	Day Year	
J.		9 ☐ Unknown										
2	2	Part II. Other significant conditions of	ontributing to death bi	ut not resulting in th	ne underlying o	ause given in	Part I.				the cause of death?	
Pet	3							10	Yes 2	No 3 Pr	obably 4 🛣 Unknown	
Completed	2							24a. Was	psv	prior to o	topsy findings available completion of cause of	
5	5							perf 1□ Yes	ormed? 2√ No	death? 1 □ Yes	2 🗆 No	
a	3	25. Was case referred to medical examiner?	11				Place of Death	n (Check only	one)			
P	2	1 Yes 2 No	Hospital: 1 ☐ Inpatie				☐ Nursing Ho				cify)	
.uo		27. Manner of Death 1X Natural 5 □ Pending	28a. Date of Inju (Month, Da)		iry M	28c. Injury at Work?	,	28d. Describe	how injury	occurred		
100	5	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ury - At home, farm		1 ☐ Yes	-	28f Location	Stroot and	Number or Di	ıral Route Number,	
i,		4 Homicide determined	building, etc	c. (Specify)	1, 311001, 140101	y, onice		City or To	wn, State)	ivanibei oi ni	irai noute ivambei,	
2	5	29a. Certifier 1 Certifying Ph	vslcian: To the best	est of my knowledge, death occurred at the time, date and place, and due to the						nd manner as	s stated.	
Medical Certification:	(Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)											
Me	2	29b. Signature and title of certifier	18.		29	c. License nun	nber		29d. Date	signed (Mont	h, Day, Year)	
	D0031563 October 24,										2007	
	-	30. Name and address of person who	completed cause of d	eath (Item 23a) (Ty					3000			
		Charles M. Benner				, #205	, Silv	er Spri	ing, M	D 2090	1	
State		31. Date filed (Month, Pay, Year) CCT 2 5 2		ar's Signature								
strar		20122	UUI DESE	נ לא ע	Goselle	1						

Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Be

Certification: To

Medical

Hospital or Attending Physlcian: The law requires that the death certificate be executed after death Director:

Division or Vital Records, P.O. Box 68760,

To the Hospital within 24 hours a To the Funeral E Registrar

State

29b. Signature and title of certified

5 ☐ Pending investigation

6 Could not be determined

mD

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

D28035

Other: 4 Nursing Home

1 ∏Yes 2 ∏No

28c. Injury at Work?

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year) Oct. 20, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASIRMOHMAD F. KOLFA. M.D. 9135 Piscataway Rd. #310 CLINTON, MD 20735

5 ☐ Residence 6 ☐ Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

31. Date filed (Month, Day, Year) OCT 2 5 2007

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend PI & 25, perME, g8/5, 1/23/08 TCertificate of Death

State of Maryland / Department of Health and Mental Hygiene 2 0 0 7

TCertificate of Death

Reg. No. 35946 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Neil Randall Taylor, Jr. 1:09 A M October 23 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Harford Havre de Grace 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min. Yrs. Director 156-16-9946 82 June 19, 1925 Maine Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Ceci1 Maryland Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 112 Walnut Street 21911 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married MYes 2 ☐ No Yes, Give 1 ☐ Yes 2 X No Specify: ģ Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: natural', White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physician Medicine and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Neil Randall Taylor, Sr. Helen Frey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Betsy Taylor/Daughter 7322 Willow Ave., Takoma Park, MD 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of the Important: If its eny injury or of once. 1 Burial 2 XCremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) West Nottingham Cem. | 10-26-2007 Colora, Maryland 22. Name and Address of Facility T. Foard Funeral Home, P.A. uhoua 111 S. Queen Street, Rising Sun, MD 21911 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Bilateral **Physician** Multilobar disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner The law requires that the death certificate be executed LeThergy
Due to (or as a consequence of): anding physicien and use as the burial-trans Box 68760. Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate hes been signed rector, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. δ small bowel obstruction 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed AM yloidosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an failure autopsy perform Congestive heart
25. Was se referred to medical examiner? 1 ☐ Yes 2 No 1 Yes 2 No After this certification 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1

Yes

2€

Yes Certification: To 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 □Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō within 24 hours e To the Funerel D completely filled i Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number SURGEON 29d. Date signed (Month, Day, Year) D0062522 October 23, 2007 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAGERIND COXIVA 504 MAKYAM Lewis HAVKE DE BRACE SFOIS OM 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

OCT 2 5

	Registrar				Ce	rtificate of	Death		Reg.	No. 2	107	3591
cian	1. Decedent's Name Betty	e (First, Middle, l Je		ylor				Mon		Day	Year	3. Dime of Deat
ical iner	4a. Fecility Name (h	f not institution, g	uive street and num	iber)		4b. City, Town, o	or Location of De		ober	2 2 4c. County	of Death	1012
	Peninsula	a Review	rol Medi	cal (p.	nter	Salest	bury			Wis	6mle	<u>_</u>
	5. Social Security N	umber 6	. Sex	7. Age (In yrs. i			If Under 24 H	rs. 8. Date in. (Mor	of Birth	-		lace (State or For
r	215-26-61		1 □ M 2 K F	76	Yrs.	Wichard Bays	Tiodis IVII		8/193			yland
	Usual Residence of 10a. State	Decedent 10b. County		10c. City	y, Town or L	ocation						0d. Inside City Lin
ō	Maryland	Wicom	ico	Sa	alisbu	rv						1 X Yes 2 □
Director	10e. Street and Nur					10f. Zip Code	-		10g.	Citizen of	What Coun	itry?
	409 D	ecatur i	Ave.			21804	4			USA		
Funeral	11. Marital Status		12. Was Deced		S. 13.	Was Decedent of H	Hispanic Origin?	(Specify Yes	or No-		ce - Americ	
		ied 2 X Married		2 🔽 No		1 ☐ Yes 2 ☑ No		onto modin, o	,	Specif		hite
d by	3 Widowed		Year or Da	tes:	10.0							
Completed			Education grade completed)		(Give	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of w	vorking	161	o. Kind of B	usiness/Ind	dustry
l Ho	Elementary/Seco	ndary (0-12)	College (1-	4or 5+)		emaker	,			Domes	tic	
Be C	17. Father's Name ((First, Middle, La	st)				18. Mother's N	lame (First, I	Middle, Mai			
To B	Henry D)onaway					Radia	Jarma	an			
0.0	19a. Informant's Na			_		ing Address (Street						Code)
	Raymono	Taylor	Jr/husba	and 	409	Decatur	Ave., S	alisbu	ry, M	ID 218	04	
	20a. Method of Disp		☐Removal from S	20b. P	lace of Displemetery, cre	osition (Name of Ematory or other pla Memory	içe)	Date	200	. Location	- City or To	wn, State
	4 ☐ Donation	5 ☐ Other (Spec	cify)		Garden	S	10	/29/07		lebron		
	21. Signature of Fu	ineral Service Lin	censee	4	2	2. Name and Addre	ess of Facility Funera	1 Home	Prof	essic	nal A	ssociati
17 1	CR	100KK	eym	CFSF		501 Snov	M HIII R	d., Sa	lisbu	ıry, M	D 218	304
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Corect and Poort											
	Immediate Cause (Final disease or condition In few chine Small & Lorge Sowell Onset and D.											Interval Between
	disease or condition			. 62	1 51	uall s	ling, such as card	2 5	atory arrest, こ <i>いし</i>	l .		Interval Between
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Funeral Director		5. Social Security Number 218–24–6759	6. Sex 1 □ M 2 🟋 F	7. Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year If Ur Days Hou	ider 24 Hrs. Irs Min.	8. Date of Birth (Month, Day JUNE 20	(, Year)	9. Birthpla Countr MARY	ace (State or Foreign LAND	
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or Attend frer death Director: in by the f	Certification:	2 Accident investigned investigation i	not be 28e. Pla	ce of injury - At I	home, farm, stre sify)	M eet, factory	1 ☐ Yes 2 , office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,	
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DB7		30. Name and address of person //3 50 PEM	who completed ca	use of death (Ite	om 23a) (Type, I UARE	Print)	DRSIN ALDO	DHW RF,	ANIMARYL	AND			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physici<u>an</u> Edna M. Vincent October 2007 4:30 pM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Glen Burnie Health & Rehabilitation Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 227-24-7872 Director Virginia 80 Nov 28, 1926 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel MD Glen Burnie r 28a-f sh notified 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 21060 USA 7900 Benesch Circle, Apt. 823 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status o filed within 72 hours after de Hygiene.

other than "natural", or item Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be and Mental His marked of Pages 1 and 2 should be Jesse Horn ္ရ Barbara Christian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 206 Newport Drive, Severna Park, Maryland 21146 Josie Jagodzinski/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Oct. 26, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Burnie, MD 2007 21. Signature of June al Service Licensee 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re-piratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** orgesul /Medical Due to (or as a consequence of): Examiner Leova Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or last a consequence of): The law requires that the death certificate be executed burial-trai Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending properties for use as IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? P 1 ☐ Yes 2⊟No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of certificate has b irector, page 2 sl 24a. Was an death? 1□ Yes 2 No 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manuar of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or A 24 hours after Fo the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

2 4 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 16, Williams October 2007 12:20a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Independence Court Prince Georges Hyattsville Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** South Carolina Days 1 □ M 2 X F 99 577605904 Director 12-9 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No D.C WASHINGTON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5353 E.St. S.E 20019 ()NITED STATES Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No 3altimore, Maryland 21215-0036 Specify: BIACK 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) FEDERAL GOVERNMENT Elementary/Secondary (0-12) College (1-4or 5+) CLERK years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHRISTOPHER FOSTER CLIFFORD SHAPPELLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORDTHY WILLIAMS 1934 S.St. S.E. WASHINGTON D.C. 20020 Daugnter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State MEMORIAL 10-23-2007 SUITLAND, MARYLAND 4 Donation 5 Dother (Specify) Name and Address of Facility John T. Rhines Funeral Home 21. Signature of Funeral Service Licenses 12th St. N.E. Washington, D.C. 20017 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to infined at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of signed by the attending physician and a betached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 X Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 27. Manner of Death Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29h. Signature and title of c 29d. Date signed (Month. Day, Year)

State Registrar

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e filed (Month, Day, Year)
OCT 2 5 2007 Baren B. Specific

ess of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician October 23, Juanita Woodson 2007 6:00 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hosptial Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 4-13-1921 **Funeral** Birthplace (State or Foreign Country) Days Hours 1□ M 2√ F 202-22-2898 86 Director Charlotte, NC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov edical Examlner must be notified at 1 XYes 2 □ No Directo Prince George's Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 820 Talbert Lane 20783 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify. Specify.Black 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If Rem 27 is marked other than "natu any Injury or other traumatic event, the Medical once, 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Heat1thcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Hall Julia Bradford 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Matthews (daughter 820 Talbert Lane Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 10/29/2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Road Kuhar Brentwood, MD 20722 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** angestive HEART FAILURE /Medical Due to (or as a consequence of): **Examiner** OBSTRUCTIVE PULMUNARY HRONIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed HEPATIC burial-tran STION CONGE Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical CORONARY ARTERY DISEASE the as signed by the attending be detached for use as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ certificate has been s rector, page 2 should 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 🗹 No Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ₹No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 2 ER/Outpatient 3 DOA 27. Mannet of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) Injury 5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

State

31. Date filed (Month, Day, Year)
OCT 2 5 2007

29b. Signature and title of certifier

DASGUPTA, Hosnitelich 32. Registrar's Sign Jure

Des Juple

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

64699

29d. Date signed (Month, Day, Year)

10/23/07

7600 Coroll Avenu. Teliono Park MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	State of	Marylar		artment of H	lealth and M		2007	35952
			Registrar 1. Decedent's Name (First, Middle	Last)		Cei	illicate of t	Jeani	2. Date of Deal	eg. NoC. UU /	3. Time of Death
8	Physici /Medi		Gwynett	_		Vilson-	Newsome		Month Oct. 1	Day Yea	
	Examir	ner	4a. Facility Name (If not institution,					Location of Death		4c. County of De	ath
	100%		Crescent Citi 5. Social Security Number			(Riverda	le If Under 24 Hrs.	0.0 (0:1)	Prince G	
0	Funeral Director		578-70-4098	1 M 2 1 F	'. Age (In yrs. 54	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 14,1953 W	irthplace (State or Foreign Country)
ja.	P.		Usual Residence of Decedent						March	14 19 J.D. Wi	
	anylar show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits 1 Yes 2 □ No
	the Marylar 28a-f show notified at	Director	D.C.		Was	shingto	1				
	with t		10e. Street and Number				10f. Zip Code		1	0g. Citizen of What (Country?
	ns 23	Funeral	2316 14th St.,	N.E. 12. Was Deced	lent Ever in U	.S. 13. V	200 Vas Decedent of Hi	18 ispanic Origin? (Spe	ecify Yes or No-	U.S.A.	nerican Indian,
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or itams 23e or 28e-f show event, I're Medical Examiner must be notified at	by Fun	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Ford 1 Tes 2 If Yes, Give	es? (X) No		Yes, specify Cuba □ Yes 2 No	n, Mexican, Puerto	Rican, etc.)	Specify: B1	nite, etc.
Ö	turat	ed b	15. Decedent	Year or Da	les:	16a Deced	lent's Usual Occupa	ation		16b. Kind of Busines	
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Maryland 21215-0036	be file tal Hy d oth	Be (17. Father's Name (First, Middle, L	ast)				18. Mother's Name	(First, Middle, I	Maiden Sumame)	
yla	Ment Ment Marke Maric	2	John Wilson						e Gordor	• • • • • • • • • • • • • • • • • • • •	
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationsh							, City or Town, State,	Zip Code)
	1 and Healt Iam 2		Kelli Martin/D 20a. Method of Disposition	augnter	20b. F	Place of Dispo	14th St.	D	ash. D.C	20011 20c. Location - City of	or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show array injury or other traumatic event, its Madical Examiner must be notified at once.		1 Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (Sp		tate C	cemetery, cren C. Oliv	natory or other place	10/24/0		Wash. D.C	
Balt	Depart Import any in		21. Signature of Funeral Service L	icensee	Kom					Jenkins Fu shington,	neral Home DC 20011
	4 A		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that can	used the deat	h. Do not ente	er the mode of dying	g, such as cardiac o	r respiratory arre	est,	Approximate Interval Between
alie	Physician		Immediate Cause (Final disease or condition			40		n M-etas			Onset and Death
	/Medical Examiner		resulting in death)		r as a conseq						
		10	Sequentially list conditions,	b. — Due to to	r as a conseq	uence oti:					
	uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	3,010	. 40 4 00,1004	201100 017.					
oʻ	exect an and rial-tra	Exa	that initiated events resulting in death) Last	c. Due to (o	r as a conseq	uence of):					
8760,	cate be executed physician and the burial-transit	dical		d							
9	artifica ing ph e as th	0	IF FEMALE:								
Вох	The law requires that the death certific lie has been signed by the attending p bage 2 should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	I death 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
o.	at the de by the a tached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnai	nt at time of do vn	eath 5∐	Other (specify)				
Ω.	res that I	y Ph	Part II. Other significant condition	s contributing to dea	th but not resi	ulting in the un	derlying cause give	in in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Records,	w requires been sign should be								1 □ Ye	s 2.\$ZNo 3.∏F	Probably 4 Unknown
၀၀	aw re	Completed							24a. Was a	n 24b. Were	autopsy findings available ocompletion of cause of
		E O							autops perform	ned? death?	s 250 No
Viital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					26. Place of Death			
	Physi this c al dire	2	1 ☐ Yes 2X No	Hospital: 1 🗆 Ing		ER/Outpatient		4 KH Nursing Hon		nce 6 Other (Sp	ecify)
u o	ding F h. After funera	tion	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investiga		Day Year)	28b. Time of Injury	28c. Injury Work	at ? ′es 2 ⊡No	lad. Describe ho	w injury occurred	
Division of	or Attending Physician: ifter death. Director: After this certific in by the funeral director.	fica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place o	f Injury - At ho	ome, farm, stre	et, factory, office		8f. Location (St	reet and Number or I	Rural Route Number.
á	spital or ours after ours after ours after seral Direction of tilled in b	Certification:	4 ☐ Homicide determin	building	, etc. (<i>Specif</i>)	y)			City or Town		
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the bas xaminer: On the bas and manne	is of examinat	wledge, death tion and/or inv	occurred at the tim estigation, in my op	e, date and place, a inion, death occurre	and due to the ca	luse(s) and manner a ate and place, and du	as stated. ue to the cause(s)
ì	Mith To 1	Σ	29b. Signature and title of certifier	as Ou	1000	n C	29c. License	1852		od. Date signed (Mor	nth, Day, Year)
1	6		30. Name and address of person w					Hvattsvi1			
	Sta Registra		31. Date filed (Month, Day, Year) OCT 2 5 2007	Serene 32. Reg			J Modu	, accov +1		, 2010	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month) attu 2007 KTCBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FUTURECARE HESAPPAKE ine, trunorL 8. Date of Birth Jan. 3, 1922 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Washington, D.C. **Funeral** Months Days Hours 1**X** M 2□ F 579-03-4921 85 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified Director 1 ☐ Yes 2 No Anne Arundel Annapolis the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò 1179 St. George Drive 21409 USA or items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1★ Yes 2□ No If Yes, Give Year or Dates: WW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WW II 1 ☐ Yes 2X No Specify. White ģ Specify: 3 Widowed 4 □ Divorced "natural", Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Washington Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Navy Yard Administrative Assistant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Christian Julia Ann Willey 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jona Lee Souder/Daughter 1202 River Bay Road Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. 24 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal freen State Parklawn Cemetery Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Simmure of Fur eral Service License 22 Name and Address of Facility farranco & Sons, 495 Gov. Ritchie Severna Park Funeral Home Severna Park, MD 21146 P.A. Hwy. Part1. Enter the disease, or com-shock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Im ediate Cause (Final dis use or con il ion result in th) Physician LOSTRIDLUM PIFFICTLE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ UNG MASS 1 Yes 2 No 3 Probably 4 Unknown Completed PORIPHERAL WASCULAR DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 2 No 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Tursing Home 5 Residence 6 Other (Specify) 2 10 Medical Certification: To 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1-Natural 5 ☐ Pending investigation 24 hours after death. ie Funeral Director: A letely filled in by the filled 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

SHIGHWAY MILLERSVILLE MD ZI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 2 4 2007

31 Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🤌 🎧 35954 1 - For State Amend 26 per phys, DOR Registrar 10/26/07, LDB

1. Decedent's Name (First, Middle, Last) Certificate of Death 2. Date of Death 3. Time of Death Mon Year **Physician** lliams 2007 October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Edmonds Street 4berd Itanford een If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 200 F Months Days Min. 214-30-8976 Usual Residence of Decedent Hours Yrs. Apr: 128,1935 Director Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State worde other treumatic event, the Medical Examiner must be nutified at 1 Nes 2 No Completed by Funeral Director 28a-f therdeen Hartono 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with ō S or Items 23a Street 21 Monds 00 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 le marked other then "natural", or ite 1 ☐ Yes 2 12 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Processing Processing / Ď ine rood Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be as Frances 2 Vates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. la 20c. Cation - City or Town, State 20a. Method of Disposition ates 0 = 6 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of tmportant: If eny Injury or once. Cambridge Bucktown Conetery 10/17/07
22. Name and Address of Facility 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Henry Funeral Home, P.A. 510 washington St. Cambridge MD. 23a. Part Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final snoll cell **Physician** 2 neetrs No~ /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires thet the death certificate be executed burial-transli Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown Š signed Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Sunknown Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 → No 2 ER/Outpatient 3□ DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 Yes 2 🗆 No death. 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058475 OCTOBER 23, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHICED NIVATPUNEN ,602 SOUTH ATHOUD MEND DEL ATE. WD 51017 31. Date filed (Month, Day, Year) 32. R State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Wilson 4a. Facility Name (If not institution, give street and number) October 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 10501 Easton Memoria albo 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2**2**F 213-22-5788 Usual Residence of Decedent 3-22-5788 Feb. 9, 1929 Director Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f shov **Funeral Director** 1 PYes 2 No Talbot aston 10e. Street and Number 10g. Citizen of What Country? Street 2/601 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant I fiem 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Community Action Center upervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BenJamin Wilson ٩ Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum 7 Easton, MD. 21601 young 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Paradise Cemetery 10/27/07 4 Donation 5 Dother (Specify) Trappe, Maryland 22. Name and Address (Facility Henry Funeral Home, 21. Signature of Funeral Service Licensee MD. 21613 washington 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and a be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an this certificate has al director, page 2 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death Check onl on Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and the e of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1 AG&O, May 2007

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Austin C. Tagbo, M.D.

219 S. Washington Street, Easton, MD 2160]

			Please Type	or Print in Blac	k Ind	lelible Ink.	Ensure /	All Copies	Are	Legible.					
			for State	e of Maryland /				Mental Hy	/giene						
			Registrar		Cert	tificate of I	Death		Reg. No.	2007	35	956			
•	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of D Month	Day		3. Time of	Death			
	/Medic		Molly Weinberg 4a. Facility Name (If not institution, give street ar			A. Oh. T.				2007	8:55 A	4. M			
1	Examir	er	5225 Pooks Hill Road,	,	h	4b. City, Town, or		ın		County of Deat					
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b		Bethesd If Under 1 Year	If Under 24 Hrs			Iontgome	nplace (State or untry)	r Foreian			
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	3a or	Ē	5225 Pooks Hill Road,	17			J. S. A.								
	deatl	Funeral	11 Marital Status 12. Was	Decedent Ever in U.S. ed Forces?		as Decedent of H Yes, specify Cuba	_ :	Specify Yes or N		14. Race - Ame	rican Indian,				
9	or Ite		1 Never Married 2 Married 1 If Ye	Yes 2 X No es. Give		Yes 2 No		to nicali, etc.)		Black, White	T-77 4 .				
Ö	hours tural"	d by		or Dates:					101 10	6b. Kind of Business/Industry					
5	in 72 n "nat ledica	lete	15. Decedent's Education (Specify only highest grade comple	eted)	a. Decede Give k! lite. D	ent's Usual Occup ind of work done o O NOT use retired	ation during most of wo	rking	16b. Kii	nd of Business/i	ndustry				
72	with jiene. r thar the N	Completed	Elementary/Secondary (0-12) Colle	ege (1-4or 5+)		Owner	,		Fabric Store						
פ	al Hyg othe vent,	Be C													
<u> </u>	ould b Menta arked atic e	70 E	Aron Datlow Rose Okrantz												
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) Rhonda A. Hurwitz-Grand Dgt. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co												
e,	1 and Health Sm 27 ther t														
nor	ages int of t: if it		0a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XI Burial 2 Cremation 3 Crematory or other place) 10 / 22 / 2007 0 linear Morror land												
<u>=</u>	nit. P artme ortan injur.		4 □ Donation 5 □ Other (Specify) Judean Mem. Gdns 10/22/2007 01ney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility												
ñ	Dep Imp any	10	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 20852												
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Operations and Death and												
	Physician	W	Immediate Cause (Final disease or condition resulting in death) Adult Failure to Thrive												
	/Medical Examiner		resulting in death)	ue to (or as a consequence	,										
6	LAMINITO	_	Sequentially list conditions, b.	Cerebral V		lar Dise	ase								
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ROX	ath ce ttendii or use	Physician/Medica	23h Was decedent pregnant 23c. If ye	s, outcome pf pregnancy Live birth 2 ☐ Fetal deat	h 3□E	Ectopic pregnancy			2	23d. Date of deli Month	*				
	ne dea the ar	/sici	1 1 Ves 2 1 No 4 L	Pregnant at time of death Unknown	5 🗆	Other (specify)				WOTH	Day Y	'ear			
л О	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the		Part II. Other significant conditions contributing	to death but not resulting	in the unc	terlying cause give	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of de	eath?			
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or <	Physician: The lav this certificate has ral director, page 2.s	To B	examiner? 1 ☐ Yes 2 X No Hospital:	1 Inpatient 2 ER/O	utpatient	3□ DOA Othe	or.	dome 5█ Res		3 □Other (Spec	city)				
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_	spital ours and neral		29a. Certifier 1 X CertifyIng Physician: 1	o the best of my knowledg	je, death	occurred at the tin	ne, date and plac	and place, and due to the cause(s) and manner as stated.				11			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Examiner: On	the basis of examination a manner stated.	nd/or inve	estigation, in my o	pinion, death occ	urred at the time	, date and	place, and due	to the cause(s))			
	To th To th COTE	ž	29b. Signature and title of certifier	111						e signed (Month	, Day, Year)				
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	•		30. Name and address of person who completed				LIO-+	Uach -	to- 5	VC.					
			Michael Grady MD 4201	cathedrar AV	ciide	NW TIL4	WESL	Washing	COH D	,,					

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT 2 5 2007

Courtes

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200 35958 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ŽŽ, 2ŎÖ̈́7 October 5:30P. M George Ernest Waesche, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **1**√2 M 2 □ F Months 93 215-28-8407 Sept.28,1914 Washington,DC. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland | Montgomery Silver Spring 1 ☐ Yes 2 No 10f. Zip Code 20904 10g. Citizen of What Country? United States 10e, Street and Number 3122 Gracefield Road, T21 12. Was Decedent Ever in U.S. Armed Forces? 1∆ Yes 2 □ No If Yes, Give Year or Dates; WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Navy Position Classifier Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Ernest Waesche, Sr. Alice Lakin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3122 Gracefield Road, T21 Silver Spring, Md. 20904 19a. Informant's Name/Relationship (Type. Print) Kathryn F. Waesche -wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Monacacy Cemetery 10/24/2007 Beallsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Dementia years Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease years Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 1□ Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am pininy or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

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certificate director After this

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Division or Vital Records, P.O. Box 68760,

To the Hospital within 24 hours at To the Funeral E Hospital completely

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Cerebrovascular Accident 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) certifie 29c. License number D24035 October 24, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugenio S. Machado, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

31. Date filed (Month,

State Registrar

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 YO UNG 10 21 M /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HMORF MEDICAL RALTIMOR CENTE If Under 1 Year | If Under 24 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** -46-Months Days Hours 1 □ M 2 X F 40 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County ıral", or Items 23a or 28a-f show Examiner must be notified at 18 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Numbe Pages 1 and 2 should be filed within 72 hours after death with Funeral Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 4 Divorced "natural", Completed er than "natura", the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 7 is marked other t traumatic event, th 18 Mother's Name (First Middle, Maiden 17. Father's Name (First, Middle, Last, Be ၉ State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Roots Number, City or Town, item 27 i other tra 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ott 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Endocarditi /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a onsequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Muti System

Due to (or as a consequence of): Muti physician ar Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Onknown 2 No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? 1□ Yes 2X No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 TER/Outpatient 3□ DOA 1 Inpatient After this uneral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D-17558

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		1 - State Registrar			Certific	cate of	Death		Reg. No	2007	35960			
Physici	an	Decedent's Name (First, Middle,	Last)	A 5- 1-1				2. Date of D Month	eath Da	y Year	3. Time of Death			
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Examir Funeral	ner	,	30 Wilkens	Avenu (In yrs. last bir	thday) If U	Altir	or Location of Dea	s. 8. Date of B	irth	Balton 9. Birth Cou	- / .			
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or 28	Director	10e. Street and Number			10	. Zip Code	000		_	tizen of What Cou	untry?			
s 23a	eral	3330 Wilkens Ave		uns in Hainl	12 Woo F		.229	Chooiby Von or N		SA 14. Race - Amer	ican Indian			
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by Funeral	11. Marital Status UNI 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces?	o		specify Cub		rto Rican, etc.)	0-	Black, White	, etc.			
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shoul ind Me mark	ဥ	19a. Informant's Name/Relationship	(Type. Print)	19b	. Mailing Add	ress (Street	and Number or F	Rural Route Numi	ber, City o	or Town, State, Zi	ip Code)			
and 2 salth a		Caton Manor Nurs	sing	33	30 Wi	1kens	Avenue I	Baltimor	e, MI	D 21229				
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Menta! Hygiene Important; if item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□ Removal from State	20b. Place of cemeter	Disposition ry, crematory	(Name of or other pla	ce)	Date	20c. Lo	ocation - City or T	own, State			
:. Pag tment tant:		4 □Donation 5 ☑ Other (Spe	^{cify)} in state											
permit Depar Impor any In		21. Signature of Fundial Service Licensee Renald S. Wade, Director State Anatomy Board 655 W. Baltimore Street												
SA P		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate												
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To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death		ic pregnanc r <i>(specify)</i> _	у			23d. Date of delive Month	very Day Year			
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best o aminer: On the basis of and manner stat	examination and	, death occu d/or investig	rred at the ti ation, in my	me, date and place opinion, death occ	ce, and due to the curred at the time	cause(s , date an) and manner as d place, and due	stated. to the cause(s)			
To the Comp	M	29b. Signature and title of certifier				29c. Licens			29d. Da	te signed (Month,	, Day, Year)			
		1 Male	any was	-		D-4	1560		Or	16 ben 30	12007			
		30. Name and address of person when De. O Have	o completed cause of de	ath (Item 23a) (Type, Print)	e su	17E 208	gren	Bur	ME, MO	21061			
Sta Registr	-1	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	posite	s								

Baltimore, Maryland 21215-0036 شر Division or Vital Records, P.O. Box 68760,

		For State Registrar		State	of Ma	aryland	Depa <i>Cei</i>	artment of H rtificate of L	ealth and N D <i>eath</i>	/lental H	ygiene Reg. No. (200	7	35961
Physicia		1. Decedent's Nam	_	e, Last)		-				2. Date of D Month	eath Day	Yea	ar 3	3. Time of Death 5:13 AM ^M
/Medic Examin		Anna A 4a. Facility Name (inguelo		number)			4b. City, Town, or	Location of Death		mber 4c. 0	7 , 20 County of De	007 eath	3.13 A.
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral I	1 ☐ Never Man 3 ☑ Widowed		ried Armed 1 Tye If Yes,	Forces?			Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ♣No	Specify:	Rican, etc.)		Black, W		
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permi Depar Impor any ir		Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland												
		23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between												
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one)	1 Certifyin	Examiner: On the	the best of e basis of lanner sta	examinati	rledge, death on and/or in	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to th	e cause(s) a e, date and	ind manner place, and c	as state	e cause(s)
o the of the omple	Mec	29b. Signature and	title of certifie	r		11		29c. License	number		29d. Date	signed (Mo	onth, Day	y, Year)
F > F 0		1	tec	1 m		M		703	8478		A (, &	20	07
		30. Name and add	iress of person	who completed ca	ause of de	eath (Item :	23a) (Type.	D3	, , ,		///৩/	1. 01	~	•
7		LAWREN		TARIN	M.D	. 30	121 FI	ERRARAS	De. S.,	VER.	SPRIN	ica n	LD.	20906
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			1- For State of Maryland / Departm	nent of Health and Me cate of Death	ental Hygiene	2001	35962		
ì	Physici		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	y Year	3. Time of Death		
	/Medic Examin		Tavonne Antonio Alston-Thomas 4a. Facility Name (If not institution, give street and number) 4b.	City, Town, or Location of Death	11-06-20	County of Death	6:38 p [™]		
				Plata Inder 1 Year If Under 24 Hrs. ;	ch.	arles	e (State or Foreign		
	Funeral Director			nths Days Hours Min.	(Month, Day, Year, May 26,	Country)	s (State of 1-oreign		
	land Dw t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				Inside City Limits		
	e Mary la-f sh tified a	ctor	MD Charles La Plata				X □Yes 2□No		
	a or 28	Funeral Director	10e. Street and Number	f. Zip Code	10g. Ci	tizen of What Country?	?		
	death	neral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was	20646 Decedent of Hispanic Origin? (Spec , specify Cuban, Mexican, Puerto R	ity Yes or No-	14. Race - American I	ndian,		
36	s after ; or Ite	by Fu		es 25 No Specify:	ican, etc.)	Black, White, etc. Specify:Black			
215-003	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or Items 23a or 28a-f show snt, the Medical Examiner must be notified at	sted k	15. Decedent's Education (Specify only highest grade completed) (Give kind of the completed)	Usual Occupation	16b. K	(ind of Business/Indust			
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Maryland	should be filed nd Mental Hygi marked other martic event, t	To E		Elaine De					
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Baltimore,	of Hea		Elaine Alston-Hill/Mother 812 Wa 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State	(Name of Da	te 20c. L	ocation - City or Town,	State		
Ĕ	permit. Pages Department of I Important: If Ite any injury or o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	on Ceme	2007 Cli	nton, MD			
g	perm Depa Impo any i			W. North Ave.	and a second control of the second control o		1201		
	Ę.		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause or each line.	mode of dying, such as cardiac or	respiratory arrest,	Int	proximate erval Between aset and Death		
	Physician // Medical	Ì	Immediate Cause (Final disease or condition resulting in death) A Planta (Area Cause)	es		Or	iset and Death		
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POX 6	death certificate e attending phys d for use as the	n/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delivery			
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or vi	Physician: r this certific ral director,	To B	examiner?	examiner? Hospital: Other:					
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	e Hosp 124 ho e Fune etely f	edical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occu (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occu physician: To the best of my knowledge, death occu physician: To the best of my knowledge, death occu physician: To the best of my knowledge, death occu physician: To the best of my knowledge, death occu physician: To the best of my knowledge, death occu physician: To the best of my knowledge, death occu physician: To the best of my knowledge, death occu physician: To the best of my knowledge, death occu physician: To the best of my knowledge, death occu physician: To the best of my knowledge, death occu physician: To the best of my knowledge, death occu physician: To the best of my knowledge, death occu physician: To the best of my knowledge, death occu physician: To the best of my knowledge, death occu physician: To the basis of examination and/or investig one)	irred at the time, date and place, at ation, in my opinion, death occurre	nd due to the cause(s d at the time, date an	s) and manner as stated ad place, and due to the	d. e cause(s)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Me	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day	, Year)		
	0		30. Name and address of parson who completed cause of seath /term 20a / 7: 5:	OCME	(1	19/07			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Part A Fowler III Penn St Balhmore 2120						01			
	State Registrar NOV 0 9 2007 32 Registrar's Signature								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** A M ANNIE **ADLER** NOVEMBER 2007 8:45 Н /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOWARD VANTAGE HOUSE COLUMBIA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🖫 F Yrs. 89 08/07/1918 NY 120-07-0176 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show items 23a or 28a-f shov Iner must be notified at 1 ☐ Yes 2 ☐ No Director HOWARD COLUMBIA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 5400 VANTAGE POINT ROAD #606 21044 Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If fleam 27 is marked other than "natural", or items 23 ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify WHITE Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) TEACHER EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HERMAN PAULINE SCHIFFER DAVID ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7 HUNTERSWORTH COURT - OWINGS MILLS, MD 21117 SAMUEL ADLER / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ADELPHI, MD MT. LEBANON 11/07/2007 of Funeral Ser 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final **Physician** sertems resulting in death) /Medical Due to as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical ast attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death by the 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 this certificate has ral director, page 2 212/No 1□ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 1 TYes 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: After (Month, Day Year) Injury 1 Natural 2 Accident 5 ☐ Pending within 24 hours after uses...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier al1

Registrar
DHMH 17 Rev 1/2001

State

3

30. Name and address of person who completed cause of death (It im 20a) (Type, Print)

2007

gistrar's Signature

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 35965 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 5,_ 2007 1:40 November Burnette Virginia Isabel1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles LaPlata Civista Meuical Center If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Davs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 🛛 F 84 04-30-1923 VA Director 232-64-8720 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director WV Mercer Bluefield 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Route 4, Box 54-C 24701 by Funeral 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White 3 ⅓Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Restaurant Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Reed Mary Gibson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Route 4, Box 54-C, Bluefield, WV 24701 Ben Burnette - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 11-09-07 Roselawn Memorial Princeton, WV 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cravens-Shires Funeral Home 21. Si Juliu e of Funeral Service Licensee 3431 Coal Heritage Road, Bluefield, WV 23a. Part1. I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemig Card **Physician** 190 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) led by the a detached f 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1☐ Yes 2 💢 No director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28b. Time of 28d. Describe how injury occurred 28a Date of Injury 28c. Injury at Work? 27. Manner of Death After (Month, Day Year) Injury 5 ☐ Pending investigation 1 X Natural 1 □ Yes 2 □ No death. 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 00052919 tarring 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) arring 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Month HERMAN J. BLAKE 2:25 11 04 P^{M} 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 222 Meadow Road Pasadena Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 216-20-4999 81 04/20/1926 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 222 Meadow Road U.S.A. 21122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sheet Metal Worker Continental Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry S. Blake Matilda Rihm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Blake / Wife 222 Meadow Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Bayview Crematory: 11/08/07 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancinoma metastata Due to (or as a consequence of): Cornary S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 □ No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

burial-transit

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral Director

þ

Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Maryland 21215-0036

Baltimore,

Physician/Medical Examiner IF FEMALE: þ Be Completed

3 Suicide

29a. Certifier

4 Homicide

Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation

Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 No

5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier

6 Could not be determined

0019512

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANG C. DOH, 1600 Crain High way M. D

31. Date filed (Month, Day, Year)

Suite 206 Glen Burnie MD 32. egistrar's Signature sack.

State

Registrar

within 24 hours a To the Funeral I

the

Medical Certification: To

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** NOV BAKER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE Da om If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F 217-40-375 Days Hours Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be profited. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ATHOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🗷 Burial 2 □ Cremation 3 □ Removal from State Bel Air Memorial Gardens 11/9/07 4 Donation 5 Dother (Specify) 21. Signatury of Funeral Service Ligensee Evanstureral Chapel- (remation Services- RollAir 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANCREATIC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 1000 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes Hospital: 20 No Other: 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nun 0 (am 32. gistrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 35968 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4, 2007 10:35 PM November Adna V. Brown 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🛱 F 65 June 23, 1942 215-31-5195 Jamaica Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2√ No MD Baltimore Randallstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21133 USA 8821 Winands Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No Specify: black 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) caregiver unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Maidstone Brown Iciline Veronica Stier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janine Bagley/daughter 8821 Winands Road Randallstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature Fune I Service Licensee Konald S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ou each line. Approximate Interval Between

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" --- any injury or other traumatic event. Physician /Medical Examiner

Physician

/Medical

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attending physician and for use as the burial-tran cate has been signed page 2 should be det within 24 hours after dea To the Funeral Directo completely filled in by the

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician:

	mmediate cause (Final disease or condition esulting in death) a. LUMG CAPUEE					
er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of): Due to (or as a consequence of):	t			
Be Completed by Physician/Medical Examiner	Cause. Liner Univerlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):				
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	in the past 1€ propules? 1 ☐ Yes 2 No 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown	Month Bay Year			
		ontributing to death but not resulting in the underlying cause given in Part	I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
			24a. Was an autopsy performed? 1 ☐ Yes 2 ■ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ■ No 24a. Was an autopsy findings available prior to completion of cause of death?			
	25. Was case referred to medical examiner?		f Death (Check only one)			
2	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 N	lursing Home 5 ☐ Residence 6 Nother (Specify)			
	27. Manner of Death Natural 5 Pending Accident investigation	1	28d. Describe how injury occurred] No			
Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
dical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and due to the cause(s) and du					
Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)			

State

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Registrar DHMH 17 Rev 1/2001

			1 - StateAmend #17&19a	Per FH G873 1	1/090er	Tificate of	Death		Reg. No	07 7	35070
	The Lat		1. Decedent's Name (First, Middle, La	ist)				2. Date of De Month	Day Day	Year 3.	Time of Death
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	Examir		4a. Facility Name (Il not institution, give			4b. City, Town, o	r Location of Death		4c. Count		
			NORTHWEST HOSP	ITAL CENTER		RANDALI	LSTOWN		BAL	TIMORE	
	Funeral			Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9. Birthplace Country)	(State or Foreign
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	70		Usual Residence of Decedent								
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	with the Maryland a or 28a-f show t be notifled at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	
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	ms ?	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No)- 14. Ra	ce - American Ir	ndian,
9	after or ite nine	Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2XX No		Tes, specify out	Specify:	y raoda, oto.,			
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21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. Ho other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notifled at	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Deced	lent's Usual Occup	oation during most of work	kina	16b. Kind of E	Business/Industr	У
2	within 7 ene. than "i	ge	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wori d)	9			
2	d wil	ő	12		DIE	TICIAN				ITION	
b	be filed tal Hygi od other event, tl	Be (17. Father's Name (First, Middle, Las	t)			18. Mother's Nam			me)	
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Maryland	d 2 should th and Mer 7 is marke traumatic	ľ	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailin	g Address (Street	ROAD, BA	ral Route Numb	ner, City or Town	, State, Zip Cod) 1 5	le)
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re	of Healt of Healt fitem 2		Barbara Snow/co	USIII 20b.	Place of Dispo- cemetery, cred	sition (Name of natory or other pla	ce)	Date		- City or Town,	
Ĕ	Pag lent nt: I		1 Burial 2 □ Cremation 3 [#□Donation 5 □ Other (Special Control of the Control		DAR HII	LL CEM	11-1	2-2007	BALTII	MORE, M	D
Baltimore,	F 22 = 2		21 Signature of Funeral Service Lice	ensee 1	. 22	. Name and Addre	ess of Facility JA	MES A.	MORTON	& SONS	F.H., INC.
Ö	permit Depar Impor any In		Lamasa	" forter			AURENS ST		ALTIMOR		21217
20			23a. Part1. Enter the disease, or con	nelications that caused the dea	th. Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory	arrest,	Ap	proximate erval Between
	Physician	0.0	srock, or heart failure. List only Immediate Cause (Final		102						set and Death
	/Medical		disease or condition resulting in death)	aDue to (or as a consec	EUME	TIME					
	Examiner					N-or	T FAI	110 Y	•		
n.		ě	Sequentially list conditions,	b. Due to (or as a conse		JIEM!	71 110	LONE			
	uted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
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68760,	certificate be executed ding physician and se as the burial-transit	/Medical									
×			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr		-			23d. D	ate of delivery	
Bo	eath atte	ciai	in the past 12 months? 1 ☐ Yes 2 ⚠ No	1□Live birth 2□Fet 4□Pregnant at time of]Ectopic pregnanc]Other (s <i>pecify)</i> _	У		N	lonth Day	y Year
P.O.	the d y the	Physician	9 Unknown	9□Unknown							
	The law requires that the death ate has been signed by the atter page 2 should be detached for u	효	Part II. Other significant conditions	contributing to death but not re	sulting in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco use cor	ntribute to the ca	ause of death?
Records,	uires sign d be	d by						1 🗆	Yes 2 No	3 ☐ Probably	y 4 ∐Unknown
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	led	one)	and manner stated.		200 Lines	se number		20d Data al	od (Manth D-	N Yoar)
	Note that	Ž	29b. Signature and title of certifier	Malla m	T-	i				ed (Month, Day	, j * L
	00		To Justy	1 1 -1/26, 1/1	<u></u>		1410		14 over	wer U	6,3001.
	4		30. Name an address of person who		em 23a) (Type,		NDER		-		
_	-				MATER	RAN	DAUST	MNJa	mo	文1137	5 .
100 N		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sigr	nature						
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State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Registrar Amend Items 25,27,28a-1 per me, 2873,11/9/07dhb Red. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Baginski Day **Physician** 6:42 PM Joseph October 28. 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Care Center Baltimore 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Hours 1**X** M 2□ F Maryland 218-36-9724 Mar 28, 1941 66 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 No Md. Baltimore Essex Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 21221 U.S.A. 18 Crafton Road Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If Item 27 is marked other the any injury or other traumany. 'natural", or Items 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping/docks Stevedore 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances C. Roth Joseph A. Baginski 19a. Informant's Name/Relationship (Type. PrintSister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Crafton Road Baltimore, Maryland 21221 Margaret M. Rasinski 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St.Stanislaus Cem 11-2-2007 Baltimore,Maryland 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses Tolund 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of): Examiner Hepatic Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. arrhosis burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Llepatitis Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 又 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Subject driver of scooter lost control and fell off 5 Pending investigation the Funeral Director: After aniately filled in by the fu 8:24a.m 1 ☐ Yes 2 No 2 Accident 3 Suicide 10/13/2006 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **Eastern Boulevard** 4 ☐ Homicide Roadway and Terrace Rd., Essex, MD Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hop Kins

32. Registral's Signature

Ky NI MD

29c. License number

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BalTimore

29d. Date signed (Month, Day, Year)

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October 30, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 2 1 Per me. 28/3, 11/09/07/dhb Reg. No. 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 203 **Physician** Year viluces Brown 00 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 2,1917 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days New York 1 □ M 2 🖫 F Months Hours 90 Director 119-20-4223 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merial Hylgiene. Important: If then 27 is anarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Columbia Director Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A. 6336 Cedar Lane #212 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Banking Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Josephine Shanahan ပ Peter Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21239 Christopher P. Brown (Nephew) 6519 Beverly Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) Metro Crematory 10-8-2007 Catonsville, MD ²². Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Col 21. Signature of Funeral Service L Columbia, MD 21045 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Physician heary /Medical Due to (or as a consequence of) **Examiner** Cardiovacular allen sclen to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed Hypertencim and Due to (or as a consequence of) burial-1 Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy as been signed by the atte 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by hbrillation 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

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To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Amend 29d, perMD, g873, 11/9/07 TT Certificate of Death Reg. N2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ciertrude November 5 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner Nursing Home towaro If Under 24 Hrs 9. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Y 5. Social Security Number 6. Sex 7. Ne (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F MD 214-18-2305 Usual Residence of Decedent Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location , or Items 23a or 28a-f show or other treumatic event, the Medical Examiner must be notified at 1 **Y**es 2 □ No Baltimore MD **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 Hvenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retified) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If Item 27 is marked other than any injury or other treumests. Elementary/Secondary (0-12) College (1-4or 5+) rse 17. Father's Name (First Middle, Last) ames Baraco 19b. Mailing Address (Street and Number or Ru Grand 3314 Honey Bee. Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service t Balto, MD 2/229 Pile. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosclerotu. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 540 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner been signed by the attending physiclen and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 3 Probably 4 Dinknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has 1 ☐ Yes 2010 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred el or Attending P s after death. Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel of within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 030641 aur Nov. 5, 2007 Back River Neck Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 201= Sabapally 32. Registrar's Statature 31. Date filed (Month, Day, Year) NOV 0 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35975 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 31 Vol 200 /Medical 4c. County of Death wn, or Location of Death Examiner ienera umbia towar last birthday 8. Date of Birth (Month, Day (ear) 5-9-194 9. Birthplace (State or Foreign Country) **Funeral** Days Min 1**X** M 2□ F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State at 1 Yes 2 No other traumatic event, the Medical Examiner must be notified Funeral Director umbia towarc 28a-f 10g. Citizen of What Country? 10e. Street and Nup 10f. Zip Code ō 21045 ane 'natural", or items 23a TOT Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ plan 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. 90 NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) ompu erman **Syrs** 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental 16 Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Department of Health ar Important: If Item 27 is any Injury or other trau 20b. Place of Disposition

• cometery, cremator 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie Batto, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** therose rais /Medical Due to (or as a conseque-ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Box 68760,02 Due to (or as a consequence of) Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Year for Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes Division or Vital Records, P.O. cate has been signed by the page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a Was an autopsy certificate has 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 2 No Hospital: Other: 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 Nursing Home Certification: To 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) After this 28c. Injury at Work? 27. Manner of De 28a. Date of Injury 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending 1 🗌 Yes 2 🗀 No investigation Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral E filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who

Month, Day,

2007 9

cause of death (Item 23a) (Type, Print)

Registrar

State

DHMH 17 Rev 1/2001

CMSC

32. Segistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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9 2007

DAVID

31. Date filed (Month, Day, Year) NOV 0

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BALAMORE

MO 21287

State Registrar 29b. Signature and title of certifier

of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State Registrar	,	-	partment of Health and ertificate of Death		eg. No.	3597
	1. Decedent's Name (First, Middle, Li	ast)			2. Date of Deat Month	th Day Year	3. Time of Death
nysician		Jasen	Anthony	Bullinger, Jr.		06 07	210 A M
/Medical Examiner	4a. Fecility Name (If not institution, gi	ve street and number)		4b. City, Town, or Location of Di	eath	4c. County of Dee	eth
	FRANKLIN SQUO	Re HOSPITA	L Cente	R Rosedale		Baltin	
neral	5. Social Security Numbeunk 6.		n yrs. last birthda	v) If Under 1 Year If Under 24 h	Irs. 8. Date of Birth in. (Month, Day,	Year) 9. Bi	rthplece (State or Foreig country)
ctor		IM ZUF	N/A ^{Yrs.}	1	Nov. 6,		aryland
527	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or	Location			10d. Inside City Limit
any njury or other traumatic event, the Medical Examinat must be notified at once. To Be Completed by Funeral Director							1 ☐ Yes 2 💆 N
Director	Maryland Han	rford		Belcamp 10f. Zip Code	1	Og. Citizen of What C	ountry?
급	1216 Halls Ch	ance Tane		2101		United St	,
Funeral	11. Marital Status	12. Was Decedent Eve	r in U.S. 13			14. Race - Am	
E	1 Never Married 2 Married	Armed Forces?		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, Wh	ite, etc.
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No Specify:		Specify: Wh	nite
Completed	15. Decedent's E		16a. Dec	edent's Usual Decupation		16b. Kind of Business	
be	(Specify only highest g. Elementary/Secondary (0-12)	College (1-4or 5+)	life	ve kind of work done during most of . DO NOT use retired)	working		
Con	N/A			Dependant		N/A	
Be (17. Father's Name (First, Middle, Las				Name (First, Middle, I		
2	Jasen Anthony	Bullinger, S	Sr.	Ma	ary A. Mac	hovec	
	19a. Informant's Name/Relationship		19b. Ma	iling Address (Street and Number of	Rural Route Number	r, City or Town, State,	Zip Code)
	Mr. Jasen A. Bul			6 Halls Chance L			
	20a. Method of Disposition X Burial 2 □ Cremation 3		20b. Place of Dis cemetery, cr	position (Name of rematory or other place)	Date	20c. Location - City o	r Town, State
1	`4 □Donation 5 □Other (Spec		Sacred :	Ht. of Jesus Cem	. 11/9/200	7 Dundal	, Maryland
	21. Signature of Funeral Service Lice	ensee		22. Name and Address of Facility Duda-Ruck Funera	Home of	Dundalk 1	Tng.
	Delice.	<u> </u>	7	922 Wise Ave. I	undalk, Ma	aryland 21	222
dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Einst Unide Hyring Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	Prematurit IT CERVIX	Y		Onset and Death
√/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p				23d. Date of d	elivery
Physiclan/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		B ∐Ectopic pregnancy □ Dther (specify)		Month	Day Year
by	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause given in Part I.	23e. Did to	_/	to the cause of death? Probably 4 Unknow
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Completed					 autops perfor 	med? prior to	completion of cause of
					1 ☐ Yes		s 2 No
Be	25. Was case referred to medical examiner?	Hospital:	-5.500	Other	Death (Check only or		
- T	1 Yes 2 No 27. Manner of Death	1 Inpatient	2 ER/Outpati	ent 3 DDA 4 Nursir		ence 6 Other (Sp ow injury occurred	ecity)
fon	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) Injury				
Certification:	2 Accident investigation 3 Suicide 6 Could not determined	be on Discontinuo	- At home, farm, : Specify)	street, factory, office	28f. Location (S. City or Town	treet and Number or I n, State)	Rural Route Number,
edical C	29a. Certifier 1 Certifying F (Check only one)	Physician: To the best of mainer: On the basis of example and manner stated	amination and/or	ath occurred at the time, date and p investigation, in my opinion, death o	ace, and due to the c ccurred at the time, d	ause(s) and manner adate and place, and di	as stated. Le to the cause(s)
₹ S	29b. Signature and title of certifier			29c. License number	2	29d. Date signed (Mo	nth, Day, Year)
	171	11000	,	055738		11-7-2	007
	/ / / / / /					1 1 /-	
	30. Name and address of person who	completed cause of death	h (Item 23a) (Tyro			11 1 2	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Emily Bimestefer 8:30 A M November 2007 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ivy Hall Geriatric Center Baltimore Middle River if Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 94 218-76-4123 Director 03/15/1913 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ?7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Maryland 1 ☐ Yes 2 No Baltimore Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2316 Martin Drive 21221 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If flem 27 is marked other the any Injury or other trainmant. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Miller Nelson ္ပ Lucy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Essex, Maryland 21221 2316 Martin Drive David Bimestefer - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriai 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 11/10/2007 Baltimore, Maryland 4 Donation 5 DOther (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part I. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease of condition resulting in death) ementia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): sician Physician/Medical the attending I IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 4 Munknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2▼No 24a. Was an ate has t autopsy 1 Yes 2 No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2X No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760, 45 Division or Vital Records, Attending death. within 24 hours after death

To the Funeral Director:
completely filled in by the ō Hospital

Medical

6 Could not be determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29b. Signature and title of certifier

hukwuna

(Check only

D0061907

Avenue Bultimore

State Registrar

31. Date filed (Month, Day, Year) NOV 0 9 2007



		For State Registrar	Glate of Ma		ertificate of	Health and M <i>Death</i>		g. No.2007	35980
Physici	ं ian	1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month	Day Year	3. Time of Death
/Medi	cal	Edward Lee Bowi 4a. Facility Name (If not institution, gi			Alta Cita Tayun	art coation of Doath	November		2015 ^M
Examir	ner		_ ′			or Location of Death		4c. County of Deat	
Funeral		Suburban Hospit 5. Social Security Number 6.		(In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth	Montgor 9. Birt	hplace (State or Foreign untry)
Director		579-26-6416	1⊠M 2□F	83 Yrs.	Months Days	Hours Min.	(Month, Day, June 21,	1924 Wasi	nington, D.C
pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			11100	10d. Inside City Limits
f shored at	ō								1 X Yes 2 No
the N 28a-i notifii	Funeral Director	Maryland Monts 10e. Street and Number	gomery	Chevy	Chase 10f. Zip Code		10	g. Citizen of What Co	untry?
3a or	Ö	120 Grafton Str	cost		208	15		United S	ŕ
death	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13		Hispanic Origin? (Sp pan, Mexican, Puerto	ecity Yes or No-	14. Race - Ame	rican Indian,
after or ite imine		1 ☐ Never Married 2 ☐ Married	1 X Yes 2 □ N If Yes, Give	lo	1 ☐ Yes 2 No		nican, etc.	Black, White	
hours ural",	d b	3 X Widowed 4 □ Divorced	Year or Dates:	WWII	55				Vhite
n 72 i "nat ledica	lete	15. Decedent's E (Specify only highest g	rade completed)	(Gin	edent's Usual Occu ve kind of work done . DO NOT use retire	during most of work	ing	6b. Kind of Business/	Industry
within inching	Completed by	Elementary/Secondary (0-12)	College (1-4or 5- 4	+) !	r/Operator	*	[Waste Mana	gement
e filec al Hyg othel	Be C	17. Father's Name (First, Middle, Las	st)	-		18. Mother's Name	e (First, Middle, M	laiden Surname)	
permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	70	Pleasanton Coom	nb Bowie			Dorothy	Adams		
2 sho and is ma		19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	iling Address (Street	t and Number or Rur	al Route Number,	City or Town, State, 2	Zip Code)
l and Health Im 27		Edward L. Bowie, 20a. Method of Disposition	Jr. / Son	104	South 5th St	treet, Apart		venworth, Ka	
ages nt of h		1 ☐ Burial 2 🕱 Cremation 3 [position (Name of rematory or other pla	, 210 1 -2	aber 8,	Oc. Location - City or	Town, State
iit. Partme artme ortant injury		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		Montgomer	y Crematoriu	Alle IIIC	2007	Bethesda,	Maryland
Deperment on once		M. m //	311300	M01473	Bethesda-	Chevy Chas Maryland	se, Inc.,	7557 Wis	ineral Home/ consin Avenu
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/Medical		resulting in death)		consequence of):	rure				nours
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isit sed	Examiner	Sequentially list conditions, in a cause. Enter Underlying Cause (Disease or injury		consequence of)				1	
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The law reguires that the death certificate it the has been signed by the attending physic bage 2 should be detached for use as the b			- U.						
th cer endin	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p 1□Live birth 2		B⊟Ectopic pregnanc	°V		23d. Date of del	•
e dea the at red fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown		Other (specify)			Month	Day Year
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w require been sign	Completed						24a. Was an		ntopsy findings available
ine lav zate has page 2	dmo						autopsy perform	prior to death?	completion of cause of
certificate ector, pag	a	25. Was case referred to medical				26. Place of Deat	1 Yes 2		2□No
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or attending Proysici fler death. Frector: A fer this cer n by the fureral direct	ertification:	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined		ry - At nome, farm, s . <i>(Specify)</i>	,,,		City or Town,	State)	rai riodio ridiribol,
spiral of Attending Physici ours after death, neral Director: After this cer filled in by the fureral direct	al Certification:	3 ☐ Suicide 6 ☐ Could not to determined	d 286. Place of injur	(Specify)		ime, date and place			
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Registrar

State

BOWIE, EDWARD II] ψ |07

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month November 8 2007 03:04 M Brauvi /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Baltimore If Under 1 Year If Under 24 Hrs. University of N/A Mechical Center 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Oct. 11 Birthplace (State or Foreign Country) **Funeral** Year) Days Hours 1 ☐ M 2 🛛 F Oct. PA 220-20-0783 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Normandy Drive Apt. A 21060 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Wgite Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Brown Roberta Barr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta J. Varshal (daughter) 1910 Oakley Road, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician on aestive /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Donknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending within 24 hours after dearn.

To the Funeral Director: / investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AU4176435Z18194 November

DHMH 17 Rev 1/2001

State Registrar Baltimore

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30. Name and address of poseon who completed cause of death (Item 23a) (Type, Print)

32/Registrar's Signature

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2ctober Physician Year AKMAd Coleman 30, 2007 /Medical 4a. Facility Name (If not institution, give 4c. County of Death Examiner Baltimore Baltimore 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 220-80-0035 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 Yes 2 No Funeral Director Manland 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or UST "natural", or Items Was Decedent Everin U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after l ∐ Yes 2 ☑ f Yes, Give /ear or Dates: 1 Never Married 2 Married 2 1 No altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced Be Completed th and Mental Hygiene. 7 is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unemploy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Broadway ဥ 19a. Informant's Mame/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Dianna Coleman Department of Health Important: If Item 27 any injury or other tr once, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 □Removal from State Randall Stown, Marytan 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licens 3512 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Year (Month, Day Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifiei (Check only one) the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar horn than

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year 3125PM **Physician** R. Cordara 2007 Vovember /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner Parkville Baltimore 8. Date of Birth (Month, Day, Year) Crost (enter Lare 9. Birthplace (State or Horeign Country) North Caroling If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Šocial Security Number **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 246-28-0695 1927 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ortant; If item 27 Is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore County Parkville Mariland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8500 2123 Vnited States Walther Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Mantal Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: While þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) University of MD Vurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be B Simpson Block 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (50n) Abirgam, MD 21009 Cinnamon Tree Drive. Cordara Harr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation Nov. 10. 2007 Forest Hill, Maryland Evens Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Center - Bel Air 21. Signature of Funeral Service Licensee Maryland 21050 3 Newport Drive Forest Hill Sour 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** myelogenous /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 plonths? 1 ☐ Yes 2 No 9 ☐ Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Vear 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ binknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 - No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 virsing Home 5 Residence 6 Other (Specify) 2 No 1 Tes Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? al or Attending Fafter death.

Director: After d in by the funera 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital e within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 Walther Bled Partville, MD 7/234 どわらん

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31. Date filed (Month, Day, Year)

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istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** John E. Callahan 05 2007 11 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1₩ M 2□ F 78 10-3-1929 217-24-4810 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show "natural", or Items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MDBaltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 7914 Beverly Avenue 21234 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🖺 No Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) oe filed within al Hyglene. Elementary/Secondary (0-12) 12 College (1-4or 5+) TechnoGraphics Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental is marked John J. Callahan Catherine Walsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any Injury or other trau 9133 Cowenton Avenue Baltimore, Maryland 21128 Michael Hart (Cousin) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 11-8-2007 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 21. Signature of Funeral Service Licensee Buena. 9705 Belair Rd. Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death yeus Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dise to (or as a consequence of): Examine certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 █ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation i or Attending after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ro the Hospital 1 - Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the Fun completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number November 6, 2007 and

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Sivision or Vital Records, P.O.

State Registrar 30. Name and address of person who completed cause of a sath (Item 23a) (Type, Print)

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3. Registrar's Signature

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		rar	NOV 0 9 2007 Riseur B So	all .	

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	Physici		1. Decedent's Name (First, Middle, Las Jean Emily Ch	nait				2. Date of Death Month November	Day Zugar	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, Sykesvi	or Location of Deatl	-1	4c. County of Dea	
Su	- Funeral Director		214 02 1027	9x 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Sept 12		thplace (State or Foreign ountry)
1 5	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Many Many	tor	MD Carroll	5	Sykesv1	1e				1 ☐ Yes 2√ No
	h with the 23s or 284	ai Director	10e. Street and Number 5404 Crows Nest	Court		10f. Zip Code 21784		10	g. Citizen of What C USA	ountry?
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f ehow other traumatic event, the Modical Examinal must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:		Was Decedent of If Yes, specify Cult	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify: W	
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occu	pation during most of wor	rking	6b. Kind of Business	/Industry
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DO NOT</i> use retire n planne			Montgomer	y Co. Gov.
g 2	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)	-	4134	Padimo	18. Mother's Nan	ne (First, Middle, Ma	,	
ylar	should be and Mental I marked o	To E	Frank Xavier Zamo	ostny			Anna Ma	rie Hejda		
, Mar	and 2 sho balth and n 27 Is m		19a. Informant's Name/Relationship (7 Michael Chait (sp	• • • • • • • • • • • • • • • • • • • •		-			City or Town, State, e, MD 2178	
altimore, Maryland 21215-0036	permit. Pages 1 Department of He Important: If Iten any Injury or oth		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, crei	esition (Name of matory or other pla y Cremat	ion 11-5		oc. Location - City of $ ilde{v}$ kesville,	
Balt	permit. Departr Importa		21. Signature of Funeral Service Licen Page Jacquet 9	erbert				ght Funer sville, MI	ral Home 8 21784	Chapel
68760,	death certificate be executed Water and burial-transit After use as the burial-transit	Medicai Examiner	23a. Part1. Enter the disease, or composition shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consection) Due to (or as a consection) Due to (or as a consection) Due to (or as a consection)	quence of):	BREAS		CINONT		Approximate Interval Between Onset and Death 31/3 YEA
P.O. Box 6	death ce e attendi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnand	sy		23d. Date of de Month	livery Day Year
	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions of	ontnbuting to death but not re	sulting in the u	nderlying cause g	ven in Part I.		1	o the cause of death?
Vital Hecords,	The ste h page	Completed						24a. Was an autopsy performe	24b. Were a prior to death?	utopsy findings available completion of cause of
Z Z Z	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only one,)	
	Phys this ral di	. To	1 Yes 2 No	28a. Date of Injury	ER/Outpatier	I 3 DOM	her: 4 🗌 Nursing H	ome 5 Residen	ce 6 Other (Spe	ecify)
0	Attending Phy ir death. ector: After thi by the funeral	ation	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	We	ork?]Yes 2∐No		,,	
Division of	i te	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled in	Medical	29a. Certifier (Check only one) Certifying Ph. 2 Medical Example (Check only one)	vsician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death ation and/or in	occurred at the t vestigation, in my	ime, date and place opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	1			se number		d. Date signed (Mon	
			I and the	22 July	o HiD		019419	N	ovenber	5,2007
	12	4	30. Name and address of person who	ompleted cause of death (Ite	m 23a) (Type,	Print) CATO	Alexan	E, BALTI	MARS M	5,2007 D 21229
120	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign		WE B	C - NEPK	- Office	110101	0 0 00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Thomas William Carback, Jr. 950 Nev 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BAL SKINT AGNES -1 LUDRE HOCPITAL 8. Date of Birth (Month, Day, OCt. 31 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. . Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Year) 934 1□XM 2□ F Months Days 219-30-4547 73 Director Usual Residence of Deceden 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits r 28a-f sh notified Howard 1 ☐ Yes 2 No Director Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 3 any injury or other traumatic event. the Madical Evandara most beneat the Madical Evandara most benear the Madical Evandara most benear the Madical Evandara most benear the madical Evandara most benear the madical Evandara most benear the Madical Evandara most benear the most benear the most be 1624 Brittle Branch Way 21797 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 1057— Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: White Completed by Year or Dates: 1957-63 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 National Security Computer Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Thomas Carback, Sr. Mary E. McKean P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1624 Brittle Branch Way Woodbine, MD 21797 Mrs. Joan I. Carback (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X□ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Poplar Springs Cemetery 11/10/07 Poplar Spings, MD 21. Signatu of Funeral Service License AATGAT FUNERAL HOME & CHAPEL, PA Sykesville, MD 21784 (410)-795-(Box 195) (410)-795-1400 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician BACTERELIA SEVERE WITH SEPTIC SHOCK days resulting in death) /Medical Due to (or as a consequence of): Examiner PERITONITIS UNGAL weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner as the burial-transit RENAL FAILURE that initiated events resulting in death) Last ears and Due to (or as a consequence of): attending physician certificate be Completed by Physician/Medical IF FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy be detached for in the past 12 months? Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy performed? Yes 21/No certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 1 Tyes Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Z∏ Accident 6 ☐ Could not be 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Records. ō Division

Baltimore, Maryland 21215-0036

ARBACK or Attending Physician: To the

19

(Check only one)

29b. Signature and title of pertifier

31. Date filed (Month, Day, Year)

State Registrar 29c. License number

900 CAFON BALFINORE

29d. Date signed (Month, Day, Year)

2007

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GUEORGU

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	of Maryland / Depar	tment of Heal ificate of Dea		ntai Hygien Reg. N	2007	35989
W.	Physici	an	Decedent's Name (First, Middle, Last)	W 0 1- 1-				ay Year	3. Time of Death
1	/Medic Examin		4a. Fecility Name (If not institution, give street and	number)	4b. City, Town, or Loca		November 4	c. County of Death	9:20AM M
		: 58	2888 Glenora L		Roc	kville			gomery
1.	Funeral Director		5. Social Security Number 220-28-5223 Usual Residence of Decedent			Jnder 24 Hrs. 8. ours Min. Fe	Date of Birth (Month, Day, Year ebruary 3,	9. Birth Cou 1926 M	place (State or Foreign intry) [aryland
	yland		10a. State 10b. County	10c. City, Town or Loca	ation				10d. Inside City Limits
	8e-f	Director	Maryland Montgomery			ville			1 X Yes 2 □ No
	with ti		10e. Street and Number		10f. Zip Code	0.50	10g. C	Citizen of What Cou	
	death	Funerai	2888 Glenora I 11. Marital Status 12. Was D		as Decedent of Hispan res, specify Cuban, Me	0850 nic Origin? (Specify	Yes or No-	14. Race - Amer	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Iteme 23s or 28s-f show any injury or other treumatic event, the Medical Exameter must be notified at once.	by	1 ☐ Never Married 2 Marned 1 ☐ Ye If Yes,	s 21KTNo		exican, Pueno Ric	an, etc.)	Black, White Specify:	White
5-0	"natu	Completed	15. Decedent's Education (Specify only highest grade complete	d) (Give kii	nt's Usual Occupation nd of work done during O NOT use retired)	g most of working	16b.	Kind of Business/Ir	
212	J withir pene. r then	omo	Elementary/Secondary (0-12) College	2 (1-4or 5+)	Owner			Antio	lues
p	be filed tal Hyg d othe	Be C	17. Father's Name (First, Middle, Last)			Mother's Name (F		n Sumame)	4000
<u>Z</u>	hould d Men marke matic	스	William Nelson Morell 19a. Informant's Name/Relationship (Type, Print)	19h Mailing	Address (Street and N		enche Lou		in Codol
Ma	alth an 27 le		Edward P. Crockett/ H		Glenora L				
Baltimore,	of He		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal fro	20b. Place of Disposit cemetery, crema	tion (Name of tory or other place)	Date		Location - City or T	
Ē	it. Pagintent rtant: njury o		4 ☐ Donation 5 ☐ Other (Specify)	Cremator	ium Inc.	Nov. 11,	2007 3	ethesda,	Maryland
Ba	Depa Impo any i		21. Signature of Funeral Service Licensee	M00335 R	ockville, ockville,	Inc. 300 Maryland	West Mon 20850-2	nphrey Fi ntgomery 805	ineral Home/ Avenue
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or Immediate Cause (Final	at caused the death. Do not enter n each line.	1.	1	1		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	to (or as a consequence of):	cardio	vasculo	ar dis	ease.	years
	Examiner								/
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of):					
oʻ	ifficate be executed g physicien and as the burial-transit		resulting in death) Last C. Due to	to (or as a consequence of):					
68760,	ate be shysici the bu	edical							
ox e			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, or	outcome of pregnancy				23d. Date of deliv	1001
m O	The law requires that the death certiste has been signed by the ettending page 2 should be detached for use a	Physician/M	in the past 12 months?	e birth 2 Fetal death 3 E gnant at time of death 5 C	ctopic pregnancy Other (s <i>pecify</i>)			Month	Day Year
<u>s</u> ,	res that the de signed by the e be detached f	by PI	Part II. Other significant conditions contributing to	death but not resulting in the unde	erlying cause given in I	Part I.		1.7	the cause of death?
Records,	w require been si should I	leted	Emphysema Dibnill	Hinn		<u> </u>	1 ☐ Yes 2 24a. Was an		bably 4 □Unknown
Š.	The lay	Completed by	HTYIGI TIPNIIL	x / / U//			autopsy performed?	prior to co death?	opsy findings available ompletion of cause of
Vital		Bec	25. Was case referred to medical examiner?		1	Place of Death C	The second second second	1 10163	24,110
	Physic rthis o	5		Inpatient 2 ER/Outpatient te of Injury 28b. Time of			5 Residence	6 ☐Other (Speci	ify)
<u>0</u>	Attending P death. ctor: After t y the funera	atlon	1 Natural 5 Pending (Mo	te of Injury onth, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Tyes		, 2000, 20 110W 117	., occurred	
Division of	Hospitel or Attending Physician: 24 hours after death. Funarel Director: After this certificitely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined but	ce of Injury - At home, farm, stree Iding, etc. (Specify)	t, factory, office	28f.	Location (Street a City or Town, State	and Number or Rur te)	al Route Number,
	To the Hospitel or A within 24 hours after To the Funarel Directorpletely filled in by	Medical	(Check only 2 Medical Examiner: On the	the best of my knowledge, death of basis of examination and/or investance stated.	occurred at the time, da stigation, in my opinion	ate and place, and n, death occurred a	due to the cause(s at the time, date ar	s) and manner as s nd place, and due t	stated. to the cause(s)
•	vithin 2 To the complei	×	29b. Signature and title of certifier	e May, Mid	29c. License num	5191E	29d. D.	ate signed (Month,	Doy, Year)
	Ó		30. Name and address of person who completed ca	use of death (Item 23a) (Type, Pri		0_100	Dank	willo n	ND MOREN
is.	Sta	te	31. Date filed (Month, Day, Year) 32.	Registrar's Signature	VIIIE FINE	j 6-11/V)	NOCK	VIIIE) 11	111 2000
	Registr	ar	NOV 0 9 2007	RALLIEN SU JAJOR	A STATE OF THE STA				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6, November **Physician** 2007 CHURCH CALVIN NELSON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore None Keswick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Nin. | Nin. | Necessity | Necessity | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Nin. | Ni 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral 1**XXM 2□ F 95 213-01-1793 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at XXX es 2□No Director Maryland None Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 21211 USA 700 West 40th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? ₩XYes 2□NoWWII I Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XXNo Specify. ò Specify: 3XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nit. Pages 1 and 2 should be filed withir artment of Health and Mental Hygiene. ortant: If Item 27 Is marked other than Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Accounting Analyst Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Wilson Church Elizabeth Gibson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Phebus P₀A 100 A East Melrose Avenue Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 ☐Removal from State permit. Page Department o Important: If any Injury or 11/13/07 Owings Mills, Maryland Garrison Forest Veterans □Donation 5 □Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral unis 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** CErebrousular Accident unknows /Medical Due to (or as a consequence of) Examiner Huper tersion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Division or Vital Records, P.O. Box 68760, attending physician and for use as the hirial-from Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 2 No 3 Probably DEMENTIA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has page 2 1□ Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

3612

31. Date filed (Month, Day, Year)

MO

BCIL

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Falls

D0059056

Dalject S. Salvic MP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend19b, perFH, & 25, perME, g873, 11/9/Or Tificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Month Year 0240 Each gasar 0 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 04 Man IMOY land N/A 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea) 02/05/1921 Birthplace (State or Foreign Country)
 As T Hours Days 1□M 20 F MΙ 382-07**-**0524 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County HOWARD COLUMBIA MD 1 □Yes 2 No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code U.S.A. 21044 6336 CEDAR LANE APT. 288 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROSENBLATT BELLA WEINBERG HASKELL 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code)
4652 OLD DRAGON PATH - COLUMBIA, MD 21042 19a. Informant's Name/Relationship (Type. Print) KATHY CEASAR / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 11/08/2007 TOWSON, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS. INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE. MD 21208 Cenhs-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to for as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a constant ence of) W. Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 √Yes € Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Oct. 27, 2007 UNKnown 1 ☐ Yes 2 No

Box 68760. P.O. Division or Vital Records,

bunial-transit death certificate be executed and physician for use ed by the a signed to page 2 should certificate has After this funeral

Certification: To

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

Physician/Medical þ Completed Be

Medical

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

Examine

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

State Registrar

29c. License number

olumbia, MI 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6336 (eday LA)

29b. Signature and title of certifier

6 Could not be determined

home

29d. Date signed (Month, Day, Year)

30. Name and accress of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Greene St. 225.

Baltimore, MD 21201

31. Date filed (Month, Day, Year) NOV 0 9 2007 32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

nursing

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stata Registrar	State of Man	yland		rtment tificate				Rag. N	711117	35992
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Las EARL H. 4a. Facility Name (If not institution, give I665 MAL	Do			4b. City, To	own, or Loca CE F	ation of Deal	2. Date of D Month	- 1	Year Year C. County of Dec	
	Funeral Director		5. Social Security Number 5. Social Security Number 6. S 214-16-3462 Usual Residence of Decedent	ex 7. Age (l.	n yrs. la 87	st birthday) Yrs.	If Under 1 Months		Inder 24 Hrs ours Min.		Day, Yea	9. Ba	rthplace (State or Foreign country) ryland
	e Maryland Sa-f show	ctor	10a. State 10b. County MD Calvert			Town or Lo	cation Freder	ick					10d. Inside City Limits 1 ☐ Yes ② No
	h with th	al Dire	10e. Street and Number 1665 Mallard Pos	int Road			10f. Zip C	ode 206	78		10g. C	itizen of What C USA	ountry?
920	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "neturel", or Items 23e or 28a-f show event, tre Medical Examirer must be multipled at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S		Vas Deceder Yes, specify		ic Origin? (Sexican, Puer	Specify Yes or Note Rican, etc.)	No-	14. Race - Am Black, Wh Specify:	
21215-0036	within 72 ho iene. 'than "netur ine Modical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)		(Give life. L	lent's Usual (kind of work OO NOT use	done during retired)				Kind of Busines	
Maryland 2		To Be Co	17. Father's Name (First, Middle, Last) Sewell Dorsey	0		_main	enanc	18.1	Mother's Na	or me (First, Midd. Towler		Calvert en Sumame)	Co Govt
	1 and 2 sh Health and Sm 27 is m Iher treum		19a. Informant's Name/Relationship (1) Betty Southard/da 20a. Method of Disposition 1□Buriai 2□Cremation 3□	aughter	20b. Pla	1665 ce of Dispo		rd Po:			ice I	or Town, State, Frederic Location - City o	k, MD 20678
Baltimore,	permit. Pages Department of I Importent: If ite any injury or of		'4 ☑ Donation 5 ☐ Other (Specify 21. Signature Fun_all vice Licented Konald S.)		222 S	.Name and tate A	Address of natom	y Boa:		W. B	altimor	e Street
	Pnysician		23a. Part1. Enter the disease, of compshort, or heart failure. List only Immediate Sause (Final disease or condition resulting in death)	olications that caused the one cause on each line.		Do not ente		of dying, suc	ch as cardia	c or respiratory		RE	Approximate Interval Between Onset and Death
8760,	/Medical Examiner uh/sician and the priral-transit the prival-transit the priral-transit the priral-transit the prival-transit the prival-t	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	Diseque	y mee of):	A	RTE	RY	DI	S €	RE ASE	y .
P.O. Box 687	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown]Fetal d	leath 3	Ectopic preg Other (spec					23d. Date of di Month	elivery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions of CHRO NIC 03.5	ontributing to death but no.					Part I.	-		./	to the cause of death? Probably 4 Unknown
of Vital Records,	The ate h page	e Completed	25. Was case referred edical							per 1 ☐ Yes	opsy formed? 2 1	prior to death?	
ion of Vil	Phys this ral dii	To B	27. M. nn. f Death 1	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye		R/Outpatien 8b. Time of Injury	3 DOA 28c		☐ Nursing I	ath <i>(Check only</i> Home 5 e 28d. Describe	sidence	6 ☐Other (Sp ury occurred	ecify)
Division	or Dir	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5	- At hom Specify)	e, farm, stre	eet, factory, o	ffice		28f. Location City or T			Rural Route Number,
	ne Hospital n 24 hours a ne Funerel bietely filled	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of m iiner: On the basis of exa and manner stated	aminatio	edge, death n and/or inv	occurred at estigation, in	the time, da my opinion	ite and place , death occ	e, and due to thurred at the time	e cause(e, date a	s) and manner and place, and du	as stated. ue to the cause(s)
)	To the Pwithin 2. To the I complete	Me		M.D.			D	icense num	1 427			ate signed (Moi	oth, Day, Year)
			30. Name and address of person who of AIV WAR MUNSHI	m. D. 110	HOS F	3a) (Type, I	RD .	RINCE	FR	EDERICA	< r	10 20	678
2	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 9 2007	32. Registrar's	Signatu	ports	ē,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 3:15 a M 2, Alan Lewis Dragoo November 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1**X**M 2□F Months Days Hours Min 8/29/1938 69 Director 371-38-6575 Michigan Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Montgomery Bethesda 1XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or items 23a or sent, the Medical Examiner must be r 9207 Villa Drive 20817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 📉 No Maryland 21215-0036 Specify:White 1 ☐ Yes 2X No Specify: 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Project Manager, College (1-4or 5+) Elementary/Secondary (0-12) 5+ Materials Scientist Dept. of Energy permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Asa Lester Dragoo Margaret Deana Lewis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary-Carrol Dragoo/wife 9207 Villa Drive, Bethesda, MD 20817 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/8/2007 |Beltsville, MD 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Service Lice M00382 Stales 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Subdural Hematoma /Medical Due to (or as a consequence of): Examiner Coagulopathy Sequentially list conditions, if any least one least cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Exami burial-trar Brain Tumor Due to (or as a consequence of) O attending physician Physician/Medical as the I IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Cinknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No certificate 1□ Yes Division or Vital 25. Was case referred to medica examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∑ Yes 2 No ၉ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Tripped on a 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 X No crack in the sidewalk 7:00 pm M 2 Accident death 10/22/2007 | 7:00 pm | 1 L 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Sidewalk <u>Dupont Circle NW Wash., DC</u> 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alexander Powers M.D.; 8600 Old Gerogetown Rd., Bethesda, MD 20814 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 9 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 5, 2007 Month **Physician** 4:05 A M Joan November ⁰/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical enter Baltimore Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□.M 2XF Days Hours Director 24,1935 Maryland 217-30-7474 Usual Residence of Decedent 10b. County 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2X No Directo Dundalk Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be r 7841 Kavanagh Road 21222 United States Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: th and Mental Hygiene.
7 Is marked other than "natural", or i traumatic event, the Medical Examir altimore, Maryland 21215-0036 1 ☐ Yes 2 No Š Specify: 3 ☐ Widowed 4 A Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tavern Barmaid 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Hennigan Emma Spielman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 21222 of Health 7841 Kavanagh Road Diane Pachilis (Daughter) item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or c Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 11/9/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Ave. Dundalk, Maryland 21222 Wise Approximate interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last This to (or as a consequence of): by Physician/Medical Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, monary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 2 No 1∐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29b. Signature and title of certifier 29c. License number 2 MD 10

Registrar DHMH 17 Rev 1/2001

State

Paul Place, Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Holly

9 2007

31. Date filed (Month, Day,

NOV 0

301

32. Registrar's Signature

5%

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 19a&b, perInf, G873, 11/13/07 Opertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Lillie B. Dover A M 1:15 11/07/2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convelesant Center Crofton Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 🗌 M 86 Director 243-26-2666 09/19/1921 North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d, Inside City Limits 1 ☐ Yes 2☐No Director Maryland Prince George's Seabrook 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 9311 Tuckerman Street 20706 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 124 Yes 2 □ No If Yes, Give Year or Dates: 43-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify. 3 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fil. h and Mental H 7 is marked oth Be John Floyd Mooneyham ျ Nannie Leona Cawthorne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau Judith Williams/ Daughter Louis Michael Doves/ Son Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 11/13/2007 Crownsville, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Robert E. Evans Funeral Home allen of 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Athnoscieratic Cerebrovascular Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): lio Vascular Di Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last o (or as a consequence of): Examine burial-tran Due to (or as a consequence of): P.O. Box 68760, aftending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>\$</u> 2 No Completed 1 Tes 3 Probably 4 Unknown need 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy page performe death? 1 ☐ Yes 2 ☐ No 1⊟ Yes or Attending Physician: 25. Was case referred to medical examiner? B 26. Place of Death (Check only one 1 Yes 2 No Other: 4 Surring Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this (28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident · death. Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after า 24 hours af ne Funeral 🕻 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and tale of certifier 0 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Rakesh Arora, MD 31. Date filed (Month, Day, Year)

14300 Gallant Fox Lane, Bowie, Maryland 20715 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien ? For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vasi **Physician** A^M November 8, 2007 1:00Margaret James Donovan /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 9000 Quintana Drive Montgomery Bethesda Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex Funeral Months Hours 1 ☐ M 2 🖾 F Director 85 July 15, 009-10-9847 Georgia Usual Residence of Decedent Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 27 is marked other than "natural", or Iteme 23a or 28a-f ehow treumatic event, the Medical Examiner must be notified at 1 TYes 2 No Directo Maryland Montgomery Bethesda the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 20817 United States 9000 Quintana Drive Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) National Library Elementary/Secondary (0-12) College (1-4or 5+) 12 Library Cataloguer of Medicine permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: if Item 27 is marked other any injury or other treumatic event, sing. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Thomas James Inez Hauser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6645 Hillandale Road, Chevy Chase, Maryland 20815 Joan Donovan / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State November 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc 8, 2007 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pr Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814-350 A. Pumphrey Funeral Home/ pc. 25757 Wisconsin Avenue 21. Signawr of Funeral Service L M01473 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ed Metas Tat7C disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Attending Physicien: The law requires that the death certificate be executed ettending physicien and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 XNo Month Year 4 Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown this certificete has been signed by all director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 6 1 Tes 2 100 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death [Check only one] examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 FR/Outpatient 3□ DOA funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury s after dea. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide ō within 24 hours a 29a. Certifie 🔾 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) om

State

Registrar

31. Date filed (Month. Day, Year)

NOV 0 9

2007

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State State Registrar	e of Maryland / Dep Ce	partment of Health a		giene 2007 35997
	hysicia /Medic		Decedent's Name (First, Middle, Last)	PREE		2. Date of Dea Month	
E	xamin		4a. Facility Name (If not institution, give street and Fort Washington Heal	d number) the Rehab	4b. City, Town, or Location of FORT WASI	f Death HING TON	4. County of Death PRINCE GEORGE'S
Dir	neral ector		5. Social Security Number 5 5. 78 − 34 − 0120 1 □ M 2 □ Usual Residence of Decedent	7. Age (In yrs. last birthday Yrs.	// If Under 1 Year If Under 2 Months Days Hours	8. Date of Birth (Month, Day	9. Birthplace (State or Foreign Country) Washington DC,
ne Marylan	Ba-r show	ctor	MD Rince George	10c. City, Town or L E'S Ft Wa			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with th	as or 2	Funeral Director	12021 Livingston	RÁ	101. ZID Code 20744		log. Citizen of What Country?
11 Z1 5-UU36 Within 72 hours after death with the Maryland with the Maryland ene.	natural, or nems 23a of 28a-1 snow idical Examinar must be notified at	by	11. Marital Status 12. Was Arme		. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☒ No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Bkack
within 72 hours aftene.	event, the Mudical I	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) 170 Colle	ted) (Giv iife.	edent's Usual Occupation e kind of work done during most DO NOT use retired)	of working	16b. Kind of Business/Industry Home warer
be filed tal Hygi	no or	To Be Co	17. Father's Name (First, Middle, Last)		18. Mother	r's Name (First, Middle,	Maiden Sumame)
Maryla d 2 should th and Men	ris mar	ř.	19a. Informant's Name/Relationship (Type, Print		ling Address (Street and Number	r or Rural Route Numbe	r, City or Town, State, Zip Code)
Heal	y or other		20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal 1 4 Donation 5 Other (Specify)	20b. Place of Disp cemetery, cre	osition (Name of amatory or other place)	Date	200. Location - City or Town, State Riverdale MD
permit. Pages Department of	any injury once.		21. Signatury of Funeral Service Licensee		22. Name and Address of Facility		SIUUPSheur St CLDE Washington DC
ate be executed EXE	the burial-transit	dical Examiner	Sequentially list conditions, b. — Du cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequence of):	of the mode of dying, such as a	CASCULA	est, Approximate Interval Between Onset and Death
DOX OF THE PORT OF	should be detached for use as	Physician/Me	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
w requires that t	ould be detac	þ	Part II. Other significant conditions contributing	to death but not resulting in the t	underlying cause given in Part I.	23e. Did to	pacco use contribute to the cause of death? Probably 4 □Unknown
ien: The law r	page 2 sh	Completed				24a. Was a autops perform	prior to completion of cause of
Physicien:	director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	I ☐ Inpatient 2 ☐ ER/Outpatie	Other	of Death (Check only on	e) ence 6 □Other (Specify)
anding Ph lath.	mera		2 Accident investigation	ate of Injury Month, Day Year) 28b. Time of Injury		28d. Describe ho	ow injury occurred
To the Hospital or Attending within 24 hours after death. To the Funerel Director: After	led in by th	Certification;	4 Homicide	lace of Injury - At home, farm, st uilding, etc. (Specify)		City or Town	
the Hosp in 24 hou	pletely fil	Medical	(Check only 2 Medical Examiner: On the one)	o the best of my knowledge, deal ne basis of examination and/or in nanner stated.	nvestigation, in my opinion, deatl	I place, and due to the ca h occurred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)
o T vitiv	con	2	29b. Signature and title of certifier		29c. License number D - 185	76 1 mm	9d. Date signed (Month, Day, Year) NOVEMBEA 5, ZOO?
ン			Name and address of person who completed	(.D. 12070	Print) Can UM	E CENT	ER WALDOF, Ud.
Re	Stat egistra Rev 1/200	ir	31. Date filed (Month, Day, Year) 3	2. Registrar's Signature	ball)		70607

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DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of Maryl	and / Depa		lealth and M	lental Hygi	iene 2007	35998
			Decedent's Name (First, Middle, Last)		Time die or		2. Date of Death	1	3. Time of Death
	Physic /Medi		Peggy Lee Eldredg	ge				October	^{Day} 2007	9:10 PM M
A. C. C. C. C. C. C. C. C. C. C. C. C. C.	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Deat	h
			16825 Wesley Char			Monkt			Baltimor	
	Funeral Director		212-34-0703	x 7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar 24,	9. Birt 1937 Ma:	hplace (State or Foreign untry) ryland
	land w ti		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f show I must be notified at	Funeral Director	MD Baltimo	re	Monkto	n 10f. Zip Code		10	Om Citizen of Miles Co	1 Yes 2 No
	with be or	흐	17127 Big Falls R	oad		21111			g. Citizen of What Co USA	unity?
	death death	nera	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
980	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Menta! Hygiene. Importent: if Item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other treumatic event, the Madical Examiner must be notified at ODGE.	ě	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1 Yes, specify Cuba 1 □ Yes 2√2 No	sn, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
21215-0036	within 72 ho ene. than "netu he Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work d)	ing 1	6b. Kind of Business/	Industry
	filed wi Hygien other th	Sol	12	3	re	gistered			healthca	re
Maryland	ntal H	Be	17. Father's Name (First, Middle, Last) Charles Frederic	l Coboonfli	-		18. Mother's Name			
Ž	hould d Mer mark	ဥ	19a. Informant's Name/Relationship (T)			Address (Street		Audrey A	ppler City or Town, State, 2	Fin Code I
Z	od 2 s lith an 27 is r treu	1 18	Robert Eldredge/sp	, . ,	1		s Road Mo		•	.ip C009/
ē,	f Hee f Hee item othe		20a. Method of Disposition	20	b. Place of Dispo				20c. Location - City or	Town, State
Ę	Page ient o nt: if ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify)	temoval from State	сатачату, стаг	natury or other plac	(8)			
Baltimore,	permit. Page Department (Importent; if eny injury or once.		21 Signalure of Fune all Privice Licens	lase Direct	or St		omy Board		Baltimore	Street
	-		23a. Part1. Enter the disease, or complesheck, or heart failure. List only or	ications that caused the	leath. Do not ent	l itimore, er the mode of dyin	MD 2120 g, such as cardiac	1 or respiratory arre	st,	Approximate
4	Physician	5	Immediate Cause (Final disease or condition	/ /	nareas	1	moor		American de la	Interval Between Onset and Death
7	/Medical		resulting in death)	Due to (or as a con		10 0	VII CUI			ZYMMINS
	Examiner		Sequentially list conditions							
	sit ad	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con	sequence of):					
_	be executed ician and burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a con	sequence of):					· · · · · · · · · · · · · · · · · · ·
760,	sician buria	calE			20400100 0171					
687	ficate p phys			1.						
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of def Month	very Day Year
	res that igned by be deta	y P	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	quires n sign	ed by						1 ☐ Yes	s and No 3□Pr	obably 4 🗆 Unknown
ပ္ပ	aw requir s been si 2 should l	Completed						24a. Was an	24b. Were au	topsy findings available completion of cause of
	The law ste has bage 2 s	E O						autopsy perform 1 Yes 2	ed? death?	completion of cause of 2□ No
of Vital	iclan: Th certificete rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Death			2010
<u>></u>	Physician: this certifice ral director, I	2	1 ☐ Yes 2 ☐ No	lospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing Ho	me Æ Resider	nce 6 Other (Spe	cify)
n C	ding P. h. After t funera	<u>:</u>	27. Manner of Death 1	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injun Worl	k?	28d. Describe how	w injury occurred	
isio	Attending ir death. ector: After by the fune	cat	Accident investigation 3 Suicide 6 Could not be	200 Plane of Injury	It ham a farm sta		Yes 2 □ No	201 Leasting (Ctr	ant and Mumbas as Co	
Division	l or Attendater death Director: In by the	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	ecify)	eet, lactory, office		City or Town,	eet and Number or Au State)	rai Houte Number,
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificete his completely filled in by the funeral director, page	Medical Co	29a. Certifier (Check only one) Cartifying Physical Examination	sician: To the best of my nar: On the basis of exam and manner stated.	knowledge, death nination and/or in	occurred at the time vestigation, in my of	ne, date and place, pinion, death occurr	and due to the cared at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of pertifier	and mainer stated.		29c. License	e number	29	d. Date signed (Monti	n, Day, Year)
	F 5 F ō		Your 10	10 Ans	Mo	D2	8929		10/3/1/	107
			30 Name of address of person who co	empleted cause of death (Item 23a) (Type.	Rrint) /			, , -, , 2	1004
			PAUL C'Elano,	NO 658	510, 0	hwles	5T B	AGTMA	emoz	1204
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature		,			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 35999

		1- For State		Certific	cate of L	Death			Reg	No	10.71
hysic Exam	ian/	Registrar 1. Decedent's Name (First, Mic		miller	- 61	lis			Date of Death Month October 22,	year 2007	3. Time of Death 1415 hrs
		4a. Facility Name (if not institu 2713 Rambler Place	tion, give street and		4b	. City, Town Hyattsvill	, or Location of e	Death		4c. County of D Prince Geo	
F.,,,,,,,		5. Social Security Number	6. Sex	7. Age (In yrs. last bi	irthday)	If Under 1	ear If Under	24Hrs.	8. Date of Birth	(MM/DD/YYYY) g	I. Birthplace (State or oreign
Funera Directo		231-74-2637	1 X M 2		Yrs.	Months I	Days Hours	Min.	7-30	1952	Country) VA
	7	Usual Residence of Decedent		10c. City, Tow	n or Location						10d. Inside City Limits
w su		10a. State 10b. Coun									1 Yes 2 No
land fsho	5	MD PRIV	ICE GEORY	e HyA	++65/1	10f Zin Con			100	. Citizen of What	Country?
death with the Maryland or items 23a or 28a-f show any	Funeral Director	Too. Ou oot and Harrison				20	783			4.5.	۸.
with t	펻	27/3 RA		Decedent Ever in U.S.	13. Was	Decedent o	f Hispanic Orig iban, Mexican,	jin? (Spe	cify Yes or No-	White e	American Indian, Black, etc.
		1, Never Married 2 3 Widowed 4	Married Arme 1 Ye Divorced If Yes, Give				No specify:	ruenon	iodii, oto.,	Specify:	BIACK
5-0036 led within 72 hours after Hygiene. other than "natural",	<u>و</u>	AS D. L. H. Education (S	or Dates:		a Decedent	s Usual Occ	upation (Give I	kind of wo	ork done	16b. Kind of Busir	ness/Industry
2 hours at "natural	ompleted	Elementary/Secondary (0-1		ne (1-4 or 5+)	-		life. DO NOT			. /	Office System
36 Pin 73 than	티월	12		10	2004	MACh	ine 1	echn	ICIAN	Digital aiden Surname)	
d with	Sol	17. Father's Name (First, Mid	dle, Last)				18.Mother	's Name (First, Middle, M	aiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be (Edwari) L.E						e Lus		
21.	ہ اۃ	19a. Informant's Name/Relati	onship (Type, Print)	19b. Mailing	Address (Street and Nun	nberorRu	ural Route Num	ber, City or Town,	State Zip Code) RICHMOND VA 23222
MD of 2 shoulth and on 27 is	other traumatic	JESS18	L &11.	s (mother)	Boxw	cock B	Ida TER	301	ImpE !	20c Location - C	City or Town. State
T and Heal	<u> </u>	20a. Method of Disposition 1 Burial 2 Crema	ition 3 Remov	/al from State 20b. Plac	e of Disposi natory or oth	tion (Name t er place)	or c en netery,		Date	200. 2004.0	,,
TOPages ent of		4 Donation 5 Other	Specify:	FOR	est La	iun Ce	eneteu	10/2	27/07	RICHMO	NO, VA. 23222
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the Apparatus of the page I are a second or the page I are a s	mjury o	21. Signature of Funeral Sen	rice Licensee	at improDer	dvr 22. N	ame and Ad	dress of Facilit	y	' '	Richmond	1, Va. 23222
		3/1. S. Cha	Vijen	N, W	W.	S.WA	TKINS	[F-1].	2700	NORTH A	t Approximate Interval
ysicia		23a. Part I. Enter the disease failure. List only one ca	use on each line.					Jarulac of	respiratory dire	, or our	Between Onset and Death
/Medica Examine		Immediate Cause (Final dise	ase a. Acute	e gastrointest	inal he	morrhag	ge				
		or condition resulting in deat	Due to (or	as a consequence of):							
	4	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consequence of):							
	۽ ۾	cause. Enter Underlying Ca (Disease or injury that initiat	od C.								
/\lambda \in \	nsit Examiner	events resulting in death) L		as a consequence of):							
ficate be executed sphysician and	- transit	1	a	6,21,22 #23a,P11,27	per fl	1 g873	11-9-	<u>07. vi</u>	t		
O, s be e	the burial - tr	X UNPENDED	A AWILING	#23a,PII,27	perME.	,g873,	11/14/0/	11		23d. Date of	delivery
8760, ificate b	s the	IF FEMALE: 23b. Was decedent pregnant		live birth	₂ Fe	tal death	3 Ector	oic pregna	incy	Month	Day Year
Box 68 e death certil the attending	iched for use as	past 12 months?		Pregnant at time of death	5 Ot	her (Specif)				
Bo deat	of for	1 Yes 2 No 9		Unknown			- una givan in S	Port I	23e Did t	obacco use contri	bute to the cause of death?
hat the	etach			ting to death but not resu	ulting in the i	underlying c	ause given in r	aiti.			Probably 4 V Unknown
cords, P.O. Box 687. Box requires that the death certifies the steep of the attending.	; page 2 should be det	Chronic alco	phol abuse_						24a. Was	an 24b. V	Were autopsy findings availab
ords v requ s been	shoul								auto	psy p	prior to completion of cause of teath?
ecc he lar	age 2	5							1 🗸 Yes		Yes 2 No
Division of Vital Records, P.O. tat or Attending Physician: The law requires that the star death. "In Director: After this certificate has been signed by	Re Con						Place of Deat			Residence 6	# Other Spans
Vita vysici this o	÷≅ ∢	examiner?			R/Outpatien		^		ng Home 5	how injury occurr	
of Vi ing Physi After this	funeral	27. Manner of Death		Date of Injury (Month, Day, Year)	28b. Time of	Injury 28	c. Injury at Wo	_	Zod. Describe	now injury occur	-
Sion Vttendi death.	the f	1 X Natural 5 Accident	Pending Investigation						20f Location	(Street and Numb	er or Rural Route Number, Ci
ViS or At Offer d	filled in by the fune	3 Suicide 6	Could not be 286	e. Place of Injury - At hom	ne, farm, stre	eet, factory,	office building,	etc.	or Town,	State)	or rara read range, e.
pital ours a	filled	4 Homicide		pecify)					l luci de dhe est	and and manne	r as stated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Futureral Director: After this certificate has been signed by the attending physicis.			ng Physician: To the	he best of my knowledge basis of examination and	e, death occu	urred at the tation, in my	ime, date and opinion, death	place, and occurred	d due to the car at the time, dat	e and place, and c	due to the cause(s)
To th	completely	2 Wiedica	_ and ma	nner stated.			License numb				ned (Month, Day, Year)
	2	29b. Signature and title of c	// /	1 1			O.C.M.E.			October 23	3, 2007
Λ		Mehna	Brassely	MA							
Ir) [30. Name and address of p Melissa Brassell,		ed cause of death (Item 2 nt Medical Examine		Penn Str	eet, Baltime	ore, MD	21201		
				#2		rede)					
	Stat gistra	162 1 647	6 2007	32 Registrar's Signatur	Part of	-					_

State Registrar

DHMH 17 Rev 1/2001

30. Name and address o

31. Date filed (Month, Day, Year)

Militello

(Type, Print)

Irumbl

Registrar's Signature

32.